

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0936-01

March 22, 2004  
IRO Certificate# 5259

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_.

### CLINICAL HISTORY

Approximately 200 pages of medical records were reviewed. 46-year-old female injured her lower back in \_\_\_\_. In April 1992 she underwent lower lumbar laminectomy and fusion. After this the patient was diagnosed with post laminectomy syndrome, chronic low back pain and lower extremity numbness. The MRI report of L-spine from September 17, 2002 was reviewed. She has undergone extensive conservative treatments including numerous epidural steroid injections, rhizotomies, trigger point injections and cryoneurolysis; none of which have been documented in the medical records provided to me, coupled with therapies aimed at functional restoration.

### REQUESTED SERVICE (S)

Epidural steroid injection with fluoroscopy and sedation

### DECISION

Uphold previous denial.

RATIONALE/BASIS FOR DECISION

This patient has had pain for twelve years and clearly displays a chronic pain syndrome. The numerous unidisciplinary treatments performed on this patient offered only temporary benefit for the last twelve years. According to Drs. Fordyce & King in their pivotal research (including peer reviewed literature), this patient is an inappropriate candidate for the requested service.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 26<sup>th</sup> day of March 2004.