

May 6, 2004

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
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Austin, TX 78744-1609

MDR Tracking #: M2-04-1211-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy board certified and specialized in Anesthesiology. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

This patient was injured on \_\_\_. He has a history of an L4/5 posterior lumbar interbody fusion in 1987. An L3/4 microlumbar discectomy was performed in 1992, although the date was not provided.

The only progress notes that were available for review were from \_\_\_ dated February 25, 2004 and a letter of appeal on March 9, 2004. In the progress note of February 25<sup>th</sup>, 2004, \_\_\_ documents that the patient has chronic low back pain with recent exacerbation of pain. A physical examination was not performed.

\_\_\_ documents results of a discogram performed on 02/24/04 demonstrating concordant pain at L5/S1, with diffuse dye spread on the post-discogram CT.

L3/4 also produced “some low back pain, but was slightly higher than his usual pain,” with post-discogram CT showing diffuse dye spread. The L2/3 disc was normal, with no pain. \_\_\_ then requested lumbar epidural steroid injection, stating the patient might ultimately require surgery, “but he wants to wait until fall.”

In the letter of March 9, 2004, \_\_\_ states that the patient has increasing low back pain, with “some lumbar disc disease.” He requests epidural steroid injections, since “the patient has had these in the remote past and they have helped his pain.” He then, however, contradicts this request, stating, “Therefore, repeat lumbar facet injections are reasonable and medically necessary.” On appeal, the epidural steroid injection was again denied.

#### REQUESTED SERVICE

Lumbar epidural steroid injections are requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

There is no documentation of radicular pain, or physical examination evidence of any radiculopathy. There is also no objective evidence of residual or recurrent disc herniation, spinal canal stenosis, foraminal stenosis, or neural compromise at any level. Based on the information that was provided, therefore, there is no medical reason or necessity for lumbar epidural steroid injection to treat this patient’s exacerbation of non-radicular lumbar pain, especially in the absence of any objective evidence of disc or nerve root pathology or physical examination evidence of radiculopathy. There is no medical evidence that lumbar epidural steroid injections have any efficacy for treatment of this patient’s clinical condition.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee’s policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

## YOUR RIGHT TO REQUEST A HEARING

Either party to 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 (28 Tex. Admin. Code 142.5(c)).

**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 142.5(c)).

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

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

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

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 6<sup>th</sup> day of May 2004.**