

May 11, 2004

MDR Tracking #:

M2-04-1237-01

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

___ fell at work in ___, striking her head and causing neck and back injury. She never had any surgery for this injury. When seen by ___ on 08/30/02, she complained of stiffness, soreness, tension, sharp pain, tenderness in hr back radiating from the neck through the shoulder blades, the entire back, her hips and "a little of butt." She was taking aspirin PRN.

In the pain diagram she filled out on that date, she shaded her neck, upper back, mid-back, and low back, as well as the shoulders, with no shading of either leg. The next visit to ___ was some six months later in February of 2003, in which she continued with the same complaints and the same pain diagram. Identical complaints and pain diagrams continued on the visits of 03/13/03 and 09/10/03.

On 09/26/03, ___ had a lumbar MRI that demonstrated a "mild concentric disc bulge" at L3/4 with "no protrusion or stenosis." A RIGHT paramedian disc protrusion was seen at L4/5 extending into the lateral recess. At L5/S1 there was no abnormality. The patient's complaints continued unchanged through October and November 2003, as well as January and February 2004. Although each and every one of the pain diagrams filled out throughout this time period documented only complaints of neck, shoulder, mid- and lower back pain, the history of present illness documented that the patient also complained of LEFT leg pain.

In a physical therapy evaluation dated 02/18/04, the physical therapist documents that the patient specifically "denies any numbness and tingling into the extremities." The physical therapist also documented that prior nerve blocks and epidural steroid injections "gave only temporary relief."

___ has requested a lumbar transforaminal epidural injection, with no documentation of the level of the proposed block, which has been repeatedly denied as not being medically necessary.

REQUESTED SERVICE

Lumbar transforaminal epidural steroid injection with anesthetic block is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Although this patient has complained of neck, mid-back, lower back and LEFT leg pain from 08/30/02 through 01/21/04, none of the pain diagrams filled out at any of the visits with ___ document any areas of pain other than the neck, shoulders, mid- and lower back. Moreover, the MRI of September 26, 2003 demonstrates no objective findings to correlate with the patient's alleged complaint of LEFT leg pain. In fact, the MRI demonstrates a RIGHT disc protrusion extending into the lateral recess at L4/5, which cannot cause left leg pain by any valid medical or physiologic mechanism.

Therefore, since the patient's pain complaints cannot be supported by objective test results, and there is no objective evidence of any left disc herniations causing either spinal cord or nerve root compromise or compression, there is no medical reason or necessity to perform transforaminal epidural steroid injections to treat the patient's left lumbar and left leg pain complaint. Contralateral pain complaints are non-physiologic and do not require or necessitate any medical treatment, especially invasive treatment.

___ 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 ___, Inc, dba ___, 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 11th day of May 2004.