

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 14, 2004

MDR Tracking #: M2-04-1295-01

IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Note: There was no separation of requester/respondent documentation; documents reviewed included:

- Office notes dated 5/14/04, 2/23/04
- X-ray report of the lumbar spine dated 2/4/04
- Peer review dated 3/2/04
- RME dated 6/10/02

Clinical History

The claimant has a history of chronic low back pain allegedly related to a compensable injury on ___. The claimant has undergone a successful lumbar fusion that was performed on 8/17/99.

Requested Service(s)

Lumbar epidural steroid injection

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally epidural steroid injection is indicated in the presence of objective documentation of radiculopathy and after documentation of failure to respond to noninvasive treatments including but not limited to nonsteroidal anti-inflammatory drugs, physical therapy (dynamic stabilization),

bracing, and oral corticosteroids. There is no objective documentation of radiculopathy. There is no documentation of exhaustion of conservative measures of treatment in this clinical setting. The claimant has a history of chronic pain syndrome that is currently managed by episodic use of oral medications, primarily analgesics and vitamins. Documentation does not support the medical necessity of the requested intervention in light of failure to clearly demonstrate the presence of radiculopathy and failure to demonstrate exhaustion of noninvasive, conservative measures of treatment.

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 (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.