

May 5, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M2-05-1323-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 4.7.05.
- Telephone request for provider records made on 4.8.05.
- The case was assigned to a reviewer on 4.28.05.
- The reviewer rendered a determination on 5.3.05.
- The Notice of Determination was sent on 5.5.05.

The findings of the independent review are as follows:

Determination

After review of all medical records provided, the PHMO physician reviewer has determined to **uphold the denial** in regards to the caudal ESI w/ Fluro and the repeat L-Spine MRI.

Summary of Clinical History

Ms. ____ injured her low back while doing inventory for her employer on ____.

Questions for Review

The prospective medical necessity of the proposed caudal ESI w/ Fluro and the repeat L-Spine MRI.

Clinical Rationale

1. Necessity of the repeat MRI

Recommendation: Denied repeat MRI. There was a lumbar MRI already completed that was normal per report without any disc protrusion, herniation, or stenosis. Moreover, the EMG was reported to be normal. The neurological examination did not show any objective deficits. There was no report that the neurological examination had changed. Dr. Henderson reported on 12/20/04 that the neurological examination was normal.

2. Necessity of caudal ESI

Recommendation: Denied. The medical literature does not validate the use of epidural steroid injections for back pain without imaging confirmation of a disc herniation or spinal stenosis. Ms. ____ does not have lumbar MRI study abnormalities.

Thus, there would be no medical necessity for the ESI.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 15 years of patient care and orthopedic surgery.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomat of the American Board of Orthopedic Surgery, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

In accordance with TWCC Rule 102.4 (h), a copy of this 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 5 day of May 2005.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas
Administrator

CC:

Robert Henderson, MD
Attn: Amanda S.
Fax: 214.688.0359

Texas Mutual
Attn: Ron Nesbitt
Fax: 512.404.3980

[Claimant]