



# Texas Medical Foundation

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phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

## NOTICE OF INDEPENDENT REVIEW DECISION

June 14, 2005

### Requestor

### Respondent

Texas Association of School Boards  
ATTN: Robin Dennis  
P.O. Box 2010  
Austin, TX 78768

RE: Injured Worker:  
MDR Tracking #: M2-05-1382-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional 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 TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This 50 year-old female injured her low back when she fell down a set of stairs at her place of employment. She has been treated with therapy and medications.

### Requested Service(s)

Outpatient lumbar epidural steroid injection X1

### Decision

It is determined that there is medical necessity for the outpatient lumbar epidural steroid injection X1 to treat this patient's medical condition.

### Rationale/Basis for Decision

Medical record documentation indicates this patient has failed other forms of conservative care. She has a dependence on narcotic pain medication and objective as well as subjective symptoms of pain. There are also positive findings on the lumbar magnetic resonance imaging and lower extremity electro-diagnostic studies. National treatment guidelines allow for this type of treatment for this type of injury given the subjective, objective and diagnostic findings. Therefore, the outpatient lumbar epidural steroid injection X1 is medically necessary to treat this patient's medical condition.

This decision by the IRO is deemed to be a TWCC decision and order.

**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 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, Fax: 512-804-4011.

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

Sincerely,



Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm

Attachment

cc: Program Administrator, Medical Review Division, TWCC

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 14<sup>th</sup> day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #: M2-05-1382-01**

**Information Submitted by Requestor:**

- Progress Notes

**Information Submitted by Respondent:**

- Required Medical Evaluation
- Diagnostic Tests
- Medical Impairment Rating
- Claims