

NOTICE OF INDEPENDENT REVIEW DECISION

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November 11, 2005

Requestor

Respondent

Amerisure Mutual Insurance
ATTN: Ray Orren
P.O. Box 569680
Dallas, TX 75356

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-06-0175-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC 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 TMF physician reviewer who is board certified in Orthopedic Surgery, by the American Board of Orthopaedic Surgery Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1964, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work related injury on ___ when he was unloading a truck when the pallet he was using caught and jerked and twisted his back. He complains of neck, upper back, and low back pain.

Requested Service(s)

Lumbar epidural steroid injection of L5-S1, epidurography, radiological supervision and interpretation

Decision

It is determined that the lumbar epidural steroid injection of L5-S1, epidurography, radiological supervision and interpretation are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

There is no indication for lumbar epidural steroid injections of L5-S1. The studies indicate that the patient had multiple levels of degenerative disc disease throughout the entire spine area. There is no significant evidence based indicia that epidural steroids in this case would produce any resolution or significant improvement. The current issue of "The Back Letter" corroborates this opinion as do the Official Disability Guidelines: ODG Treatment in Workers' Comp, 2005, Third Edition, Work Loss Data Institute. The consensus now appears to be that epidural steroids have little value or credibility. In addition, the medical record documentation indicates that the epidural steroid injection of 08/02/2005 was not efficacious. There is no medical indication for another attempt when the first attempt was unsuccessful.

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

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 Department of Insurance, Division of Workers' Compensation, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

M2-06-0175-01

Page 3

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,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

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

GBS:dm
Attachment

cc: Program Administrator, Medical Review Division, DWC

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 11th day of November 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-06-0175-01

Information Submitted by Requestor:

- Office notes
- Operative report
- MRI report of lumbar spine
- Bone scan report
- Lab reports
- X-ray report cervical spine

Information Submitted by Respondent:

- Medical dispute resolution request
- Table of disputed services
- Denial letters
- Physician office notes
- Surgery record
- Designated doctor examination
- Operative report
- MRI report of lumbar spine
- Bone scan report
- X-ray report cervical spine
- PT notes
- Claims
- Physician Activity Status Report