

  
**INDEPENDENT REVIEW INCORPORATED**

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September 29, 2006

Re:    **MDR #:**        **M2 06 1934 01**        **Injured Employee:**    \_\_\_  
      **DWC #:**        \_\_\_                    **DOI:**                    \_\_\_  
      **IRO Cert. #:** **5055**                **SS#:**                    \_\_\_

**TRANSMITTED VIA FAX TO:**  
**TDI, Division of Workers' Compensation**  
Attention: \_\_\_  
Medical Dispute Resolution  
Fax: (512) 804-4868

**RESPONDENT:**                    **Texas Mutual Insurance**

**TREATING DOCTOR:**        **Kenneth Berliner, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in orthopedic surgery and is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. 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.

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 September 29, 2006.

Sincerely,



Jeff Cunningham, DC  
Office Manager

**REVIEWER'S REPORT  
M2 06 1934 01**

MEDICAL INFORMATION REVIEWED:

1. Notification of IRO assignment
2. Medical Dispute Resolution Request/Response
3. Table of Disputed Services
4. Insurance company denial letter dated 07/21/06
5. Insurance company denial letter dated 07/23/06
6. Carrier's records including letter from Texas Mutual and carrier's statement dated 09/15/06
7. Records from Victoria Orthopedics and Sports Medicine Clinic
8. Records from Lone Star Orthopedics
9. Radiologic reports from Citizens Medical Center, MRI scan of the lumbar spine
10. Requestor's records and operative reports from Renaissance Hospital, date of surgery 08/23/06
11. MRI report of left knee dated 07/13/06

BRIEF CLINICAL HISTORY:

The patient is a 60-year-old male who suffered a work-related injury due to a fall on \_\_\_\_\_. The patient injured his left knee, heel, foot, and left sacroiliac joint. The patient was treated conservatively for his back. The left knee required arthroscopic surgery. Due to persistent back pain, Dr. Kenneth Berliner requested lumbar epidural steroid injections and sacroiliac joint injection under fluoroscopy.

DISPUTED SERVICES:

Lumbar epidural steroid injections in addition to fluoroscopic sacroiliac joint injection.

DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

RATIONALE OR BASIS FOR DECISION:

The patient's sacroiliac joint dysfunction can be adequately treated with a sacroiliac joint injection. However, performing the lumbar epidural steroid injection at the same time would confuse this patient's diagnostic and therapeutic workup. I agree with the insurance's carrier to agree to approve the sacroiliac injections at this setting and not

approve the lumbar epidural steroid injection. The patient may require lumbar epidural steroid injection if the sacroiliac injection is not effective.

SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED

ODG and ACOEM Guidelines and clinical experience as a board certified orthopedic surgeon.