


INDEPENDENT REVIEW INCORPORATED

SENT TO: Texas Department of Insurance
Health & Workers' Compensation Network Certification & QA
Division (HWCN) MC 103-5A
Via Fax: 512.804.4868

El Paso ISD
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Robert Urrea, MD
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02/05/07

RE: IRO Case #: M2 07 0703 01
Name: _____
Coverage Type: Workers' Compensation Health Care - Non-network
Type of Review:
 Preauthorization
 Concurrent Review
 Retrospective Review
Prevailing Party:
 Requestor
 Carrier

Independent Review, Inc. (IRI) has been certified, IRO Certificate #5055, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to IRI for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

IRI has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, IRI reviewed the medical records and documentation provided to IRI by involved parties.

This case was reviewed by an M.D., F.A.C.S., Board Certification: American Board of Orthopedic Surgery, with experience in the evaluation and treatment of injured employees. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), and any of



the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of IRI, I certify that:

1. there is no known conflict between the reviewer, IRI and/or any officer/employee of IRI with any person or entity that is a party to the dispute, and
2. a copy of this IRO decision was sent to all of the parties via U.S. Postal service or otherwise transmitted in the manner indicated above on 02/07/07.

RIGHT TO APPEAL:

You have the right to appeal the decision by seeking judicial review. This IRO decision is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery, the appeal must be filed:

1. directly with a district court in Travis County (see Labor Code 413.031(m)), and
2. within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

Jeff Cunningham, D.C.
Director of Operations

**REVIEWER REPORT
M2.07.0703.01**

DATE OF REVIEW: 02/05/07

IRO CASE #: M2-07-0703-01

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar facet joint blocks and epidural steroid injections.



DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., Board Certification: American Board of Orthopedic Surgery, with experience in the evaluation and treatment of injured employees

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

M.D.’s medical records from 04/19/00 through 11/21/06

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This now 52-year-old female employee suffered a complex lumbosacral spine strain/sprain and possible direct blow injury in a fall on 03/10/00 while performing lifting and throwing functions. Her evaluation and treatment ultimately led to a multilevel endoscopic discectomy on 06/08/04. She has now moved into what is best described as chronic lumbosacral pain.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

There are no clear guidelines that would dictate the best course of action for this patient. There is a suggestion that she may be suffering an element of instability, though clear documentation of L5/S1 instability is not present. She may be suffering the evolving consequences of degenerative disc disease. There are inconsistent injections in the past that epidural steroid injections have been beneficial. It would appear that this patient needs a pain management consultation outside of the development of impairment ratings and dates of maximum medical improvement.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPR-Agency for Healthcare Research & Quality Guidelines.
- DWC-Division of Workers’ Compensation Policies or Guidelines.

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- European Guidelines for Management of Chronic Low Back Pain.
- Interqual Criteria.
- Medical judgement, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)