

January 13, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-03-0472-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on \_\_\_ external review panel. This physician is board certified in anesthesiology. \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 41 year-old female who sustained a work related injury on \_\_\_. The patient reports previously injuring her back in \_\_\_, but that she had returned to work on light duty. The patient reports that on \_\_\_ she was unloading a truck and pulling a six-wheeler onto the floor when she started having pain of the thoracic and lumbar areas. The diagnoses for this patient are lumbar discogenic pain, myofascial pain syndrome, bilateral sacroiliitis, and thoracic discogenic pain. The patient has undergone X-Rays and an MRI. She has been treated with physical therapy, rehabilitation, and work hardening. She has also been treated with oral pain medications.

### Requested Services

Bilateral lumbar facet injections and bilateral S1 joint injections.

### Decision

The Carrier's denial of authorization for the requested services is upheld.

### Rationale/Basis for Decision

\_\_\_ physician reviewer indicated that this patient has sustained a work related injury to her back on \_\_\_. \_\_\_ physician reviewer also indicated that the patient underwent an MRI that showed disc degeneration and mild disc bulge at L5-S1. \_\_\_ physician reviewer noted that the patient has been treated with multiple interventions including analgesic medication, physical therapy, water exercises, chiropractic manipulative therapy and electrical stimulation. However, \_\_\_ physician reviewer explained that the patient continues to report a pain rating of 8/10. \_\_\_

physician reviewer also noted that bilateral lumbar facet and S1 injections are recommended. \_\_\_ physician reviewer explained that the medical records provided do not include documentation indicating medical necessity for the proposed injection therapy. \_\_\_ physician reviewer also explained that the patient has been evaluated by three physicians and that they found no evidence of neurogenic focal weakness or radiculopathy. MAIMUS's physician reviewer noted that the patient had been given a designation of non-malignant chronic acquired pain syndrome, symptom magnification, and probable non-organic pain syndrome. \_\_\_ physician reviewer further explained that there is no evidence that the patient has received multidisciplinary pain treatment. Therefore, \_\_\_ physician consultant has concluded that the bilateral lumbar facet injections and bilateral S1 joint injections are not medically necessary to treat this patient's condition.

This decision 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)** days of your receipt of this decision. (20 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)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 78704-0012

**A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,