

February 13, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0575-01
IRO Certificate No.: 5348

___ 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 33 year-old male who sustained a work related injury on ____. The patient reports that while at work he was pulling pallets loaded with product. The patient reported that he felt his shoulder "pop". The patient was treated with physical therapy and returned to work when he injured himself again on ____. The patient was treated with physical therapy, injection therapy with epidural steroid and Botox, and multiple oral medications. The patient also underwent cervical fusion between C3-C6 in 1999 and surgery on his right shoulder in 2000. The patient also participated in a work hardening program. The patient has had diagnostic and nerve conduction studies performed.

Requested Services

Eight Botox Injections with EMG Guidance.

Decision

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

Rationale/Basis for Decision

___ physician reviewer indicated that the patient has a documented history of chronic neck and shoulder pain. ___ physician reviewer noted that the patient's condition requires long term-therapy. ___ physician reviewer explained that the patient has completed courses of

conservative therapy including a work hardening program, without complete relief of pain. ___ physician reviewer noted that the patient had been maintained on medical therapy and Botox therapy has proven to be a successful intervention for him. ___ physician reviewer also noted that the patient has reported an 8-month period of substantial pain relief. ___ physician reviewer explained that the patient has a documented recurrent cervical spasm and Botox is clearly indicated as a treatment for this condition. ___ physician reviewer also explained that the patient has undergone all other therapeutic modalities for long-term pain relief. ___ physician reviewer further explained that Botox is a significant part of this patient's treatment plan. Therefore, ___ physician consultant has concluded that the requested 8 Botox injections with EMG guidance is 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,

State Appeals Department

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 13th day of February 2003.