

February 21, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0616-01

___ 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 the ___ 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 42 year-old male who sustained a work related injury on ___. The patient reported that while at work he incurred a bruise to the left side of his chest and abdomen when he fell, breaking his fall and twisting the thoracic spine. The patient reported that at the time of injury, he developed pain beginning in the mid thoracic area radiating around anteriorly and underneath his left breast area. The patient has undergone X-Rays and an MRI. The diagnoses for this patient include degenerative spine and disc disease thoracic T7-8, disc bulge T7-8, and clinical T7 radiculopathy on the left. The patient has been treated with physical therapy that seemed to aggravate his symptoms. The patient had epidural thoracic blocks. The patient has had prior lumbar surgery in 1985 with discectomy.

Requested Services

Selective Nerve Root Block at T7 left.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work related injury on ___. The ___ physician reviewer also noted the patient's diagnosis included a loss of disc height at T7-8

with a small broad-based disc bulge and degenerative disc disease. The ___ physician reviewer indicated that the patient has been evaluated and treated by a pain management specialist and has received interventional therapy with thoracic epidural steroid injections. The ___ physician reviewer explained that the patient experienced some relief with the steroid injections. The ___ physician reviewer indicated that the patient has also been treated with physical therapy. The ___ physician reviewer explained that the therapy aggravated the patient's symptoms. The ___ physician reviewer noted that the patient has been maintained on medical therapy with Lortab, Flexeril, and Beextra. The ___ physician reviewer also noted the patient was evaluated by orthopedics and determined not to be a candidate for surgery. The ___ physician reviewer explained that there is no documentation provided indicating the medical necessity for the requested selective T7 nerve root block. The ___ physician reviewer explained that the patient has not experienced prolonged response to previous thoracic epidurals. Therefore, the ___ physician consultant has concluded that the Selective Nerve Root Block at T7 left is not medically necessary to treat this patient's condition at this time.

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,

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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 21st day of February 2003.