

March 17, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-0681-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

\_\_\_ is a 48-year-old woman who sustained a work-related injury in \_\_\_ while employed for \_\_\_. \_\_\_ slipped on a wet wood-surface floor and fell. She had immediate pain in the lower back, right wrist, right foot and right hand. She did report this to her supervisor. She was seen by \_\_\_ where she was x-rayed and was prescribed chiropractic manipulation with supportive physical therapy.

The patient came under the care of \_\_\_. A MRI of the lumbar spine demonstrated facet joint arthropathy from L3/-S1 and bulging discs at L4/5.

She was referred to \_\_\_, specifically \_\_\_ and was seen on November 20, 2002. A complete history and physical examination was provided. The doctor's diagnosis was lumbar disc syndrome, lumbar facet synrome, and bilateral sacorilities. It was recommended the patient undergo conservative treatment to include continued physical therapy, chiropractic manipulation, Ultram, Celebrex, and EMG/NCS.

The patient attended physical therapy at \_\_\_.

REQUESTED SERVICE

Requested for this patient are bilateral facet joint injections in the lumbar spine (X3) with bilateral SI joint injections (X2) for the above diagnosis by \_\_\_\_.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

After reviewing the medical records provided, it appears that this patient did sustain an acute lumbar strain/sprain aggravation of pre-existing lumbar degenerative disc disease and facet joint arthropathy. She has been treated conservatively to include chiropractic manipulation supportive physical therapy, anti-inflammatory medicines and Tylenol without resolution.

The \_\_\_\_ reviewer finds that the recommended facet joint injections and SI joint injections are reasonable and necessary therapeutic interventions at this time. The records indicate that the pain seems to generate from the facet joints as documented by \_\_\_\_ and \_\_\_\_\_. There is a MRI which is positive for facet joint arthropathy. The patient has failed conservative treatment, thus, it would be reasonable to move to the next diagnostic/therapeutic intervention, i.e. the requested procedures.

\_\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

**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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

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

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 17<sup>th</sup> day of March 2003.**