

November 24, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0688-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ 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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in anesthesiology. The ___ 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, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 40 year-old male who sustained a work related injury on ___. The patient reported that while at work he slipped and fell on a tiled floor causing injury to his back. An MRI dated 7/11/01 showed L3-4 broad posterior 2mm annular disc bulge and at the L4-5 levels a broad posterior 2-3mm disc protrusion. The diagnoses for this patient have included failed back surgery syndrome, lumbar radiculopathy, lumbar discogenic pain, bilateral lumbar facet syndrome, bilateral sacroileitis, sacrococcyxgodynia, and myofascial pain syndrome. Treatment for this patient's condition has included medications, physical therapy, chiropractic manipulation, back surgery and epidural steroid injections. The patient also has a history of back injury in ___ followed by a lumbar laminectomy.

Requested Services

Lumbar ESI with fluoroscopy & epidurogram times three, possible lysis of adhesions with spinal catheter.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 40 year-old male who sustained a work related injury to his lower back on ____. The ___ physician reviewer also noted that the patient had previously injured his back and underwent a lumbar laminectomy in ____. The ___ physician reviewer indicated that an MRI dated 7/11/01 showed broad posterior disc bulges at L3-L4 and L4-L5. The ___ physician reviewer noted that the patient has undergone numerous treatments that have included medical management, physical therapy, chiropractic manipulation and epidural steroid injections. The ___ physician reviewer indicated that the patient continues to complain of intense back pain that radiates to the hips and buttocks and down both legs. The ___ physician reviewer also indicated that the patient has associated muscle spasms and complains of bilateral leg weakness. The ___ physician reviewer explained that his exam demonstrated bilateral lumbosacral paraspinal muscle tenderness with decreased extension and flexion due to pain. The ___ physician reviewer also explained that a neurological exam indicated decreased knee jerk in the right knee and decreased response to pinprick sensation over the distribution of the L4-L5 nerve root. The ___ physician reviewer noted that the diagnoses for this patient included failed back surgery syndrome, lumbar radiculopathy, lumbar discogenic disc pain, bilateral lumbar facet syndrome, bilateral sacroileitis and myofascial pain syndrome. The ___ physician reviewer explained that the patient had previously undergone interventional therapy with epidural steroid injections and did not report significant and sustained pain relief. The ___ physician reviewer also explained that the most recent NCV studies (9/2003) demonstrated chronic nerve root irritation at the L4-L5 and L5-S1 nerve root. The ___ physician reviewer indicated that the patient is presently maintained on medical therapy that includes Elavil and Neurontin. The ___ physician reviewer explained that both of these medications are for treatment of neuropathic pain and that the dosages could be titrated upward for increased pain relief. The ___ physician reviewer indicated that the treating pain management specialist has recommended continued physical therapy, active rehabilitation and an evaluation for a behavioral chronic pain management. The ___ physician reviewer explained that the documentation provided did not show that the suggested non-interventional modalities have been tried and failed. Therefore, the ___ physician consultant concluded that the requested Lumbar ESI with fluoroscopy & epidurogram times three, possible lysis of adhesions with spinal catheter 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/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

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,

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 November 2003.