

April 3, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0696-01

___ 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. 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 45 year-old female who sustained a work related injury on ___. The patient reported that while at work she was stacking parts when a co-worker driving a forklift, hit a table that pushed into the patient, hitting her in her abdominal area and bilateral knees causing her to fall backwards. The diagnoses for this patient include cervical radiculopathy, lumbar radiculopathy, bilateral lumbar facet syndrome, right shoulder internal derangement syndrome, contusion to the bilateral knees, and myofascial pain syndrome. The patient underwent MRI of the cervical spine and right shoulder 11/9/00 and an MRI of the left knee and lumbar spine on 10/30/00. That patient has been treated with oral medications, physical therapy, left knee surgery, cervical facet joint injections, and steroid epidural injections.

Requested Services

Bilateral Cervical Facet Joint Injections.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this patient sustained a work related injury on ___. The ___ physician reviewer indicated that the patient has been under the care of a pain management specialist. The ___ physician reviewer explained that the patient has been treated

with oral medications, physical therapy, cervical facet joint injections, and epidural steroid injection therapy. The ___ physician reviewer also noted that the patient's pain management specialist has recommended another series of cervical facet injections. The ___ physician reviewer explained that the patient underwent an EMG study of the cervical spine and bilateral upper extremities. The ___ physician reviewer also explained that the EMG demonstrated evidence consistent with chronic bilateral C6-C7 nerve root irritation, partial chronic denervation, and chronic radiculopathy. The ___ physician reviewer explained that the patient underwent two separate series of cervical facet injections with only a 6% relief of pain for a short period of time. The ___ physician reviewer noted that the patient continues to complain of neck pain with daily headaches. The ___ physician reviewer explained that the documentation provided does not support the medical necessity of repeat cervical facet injections. Therefore, the ___ physician consultant concluded that the requested bilateral cervical facet joint injections are 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 3rd day of April 2003.