

June 27, 2003

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

MDR Tracking #: M2-03-1224-01
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 32-year-old woman who injured her right wrist and lower back in a work-related motor vehicle accident on ___. Apparently the patient is a bus driver whose vehicle was rear-ended by a church van at an intersection. The patient immediately notified her supervisor and a police report was made. The damage of the church van consisted of a cracked plastic grill; there was no visible damage done to the bus.

___ was initially seen by ___ on January 15, 2003. She was complaining of right wrist pain and was given the diagnosis of ganglion cyst. She was eventually seen by ___ on January 23, 2003 for complaints of lower back pain. X-rays of the lower back were essentially unremarkable. She was diagnosed with a lumbar strain and recommended physical therapy.

On April 14, 2003 she began treatment under ___ in ___. At that time he noted there was no history of lower back problems, but she was complaining of persistent lower back pain radiating to both hips aggravated by walking, standing and activities. Physical therapy has not been provided at this point. She was unable to return to work.

The records note that she was taking ibuprofen and smoking 1/2 pack of cigarettes a day. She has a history of mild diabetes and has had six C-sections. His physical examination revealed a positive straight leg raise at 45° with mild tenderness over the lower back. Reflexes were intact. There was mild tightness over the paralumbar musculature. He recommended an MRI of the lumbar spine.

An MRI of the lumbar spine was performed on April 17, 2003 that demonstrated degenerative changes at L4/5 and L5/S1 with bilateral facet joint arthrosis at that level. No true disc herniation was noted.

The patient was recommended “lumbar Depo Medrol and Marcaine injections X3”. These have been rejected by prior reviewers for “not enough detail.”

Records indicate that the patient has persistent lower back pain with no leg pain. The MRI is significant for facet joint arthropathy at L4/L5 and L5/S1. She is neurologically intact and appears to have had a course of physical therapy with no relief. The diagnosis given was a chronic lumbosacral sprain with lumbar facet arthrosis.

REQUESTED SERVICE

Trigger Point Injections (Lumbar Depo Medrol and Marcaine injections X3) are requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer finds that the requested trigger point injections are not medically necessary or appropriate for this patient, as there is no clear documentation in ___ medical records of trigger point formation of the lumbosacral spine area.

___ 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 27th day of June 2003.