

July 21, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1268-01

___ 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 a board certified 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 54 year-old female who sustained a work related injury on ___. The patient reported that while at work she was hit with a door injuring her left shoulder, cervical spine, left breast area and head. The patient was evaluated in the emergency department where the patient underwent X-Rays and was prescribed pain medications and released. The patient was then evaluated by her treating physician. This physician treated the patient with rehabilitation and chiropractic manipulation, neuromuscular stimulator, heating pad and oral pain medications. The patient underwent further X-Rays and an MRI. The diagnoses for this patient included cervical disc syndrome, cervical facet syndrome, cervical radiculitis, left shoulder internal derangement syndrome, chest wall contusion and myofascial pain syndrome.

Requested Services

Series of 3 cervical ESI.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 54 year-old female who sustained a work related injury to her left shoulder, cervical spine, head and left breast area on ___. The ___ physician reviewer also noted that the diagnoses for this patient included cervical discogenic pain, cervical facet syndrome, cervical radiculitis, left shoulder internal derangement syndrome, chest wall contusion and myofascial pain syndrome. The ___ physician reviewer further noted that treatment for this patient's condition has included medications (Celebrex, Darvocet, Vicodin and topical analgesic gel), rehabilitation and chiropractic manipulation, neuromuscular stimulator and heat therapy. The ___ physician reviewer indicated that despite these interventions the patient continues to complain of neck pain that radiates to both shoulders. The ___ physician reviewer also indicated that an MRI indicated cervical disc disease and a neurologic exam showed diminished strength in the upper extremities. The ___ physician reviewer further indicated that an EMG confirms a left C6 nerve root irritation. The ___ physician reviewer explained that the patient has not responded to several conservative interventions. The ___ physician reviewer also explained that the requested epidural steroid injection therapy represents a logical next step for significant and sustained pain control. Therefore, the ___ physician consultant concluded that the request series of 3 cervical epidural steroid injections is 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,

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 22nd day of July 2003.