

August 8, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1546-01

___ 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 male who sustained a work related injury on ___. The patient reported that while at work he was unloading some doors from a trailer when he experienced a popping sensation in his back. The initial diagnoses for this patient included symptomatic spondylolysis/spondylolisthesis at L5-S1, degenerative disc disease at L4-L5 and L5-S1. The patient was initially treated with a course of physical therapy, oral pain medications and underwent a extensive laminectomy with cages, posterior interbody arthrodesis and posterolateral transverse process and intertransverse arthrodesis. At present the patient ambulates with a cane and is treated with medications only.

Requested Services

Botox R (Botulinuria Toxin Type A) injection to treat refractory myofascial pain and muscle spasms in the lumbar area.

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 50 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the diagnoses for this patient include post laminectomy syndrome, chronic pain syndrome and

myofascial pain syndrome. The ___ physician reviewer further noted that treatment for this patient has included conservative care consisting of physical therapy and oral analgesics, laminectomy at the L4-L5 with insertion of cages, posterior interbody arthrodesis at L4-L5 and L5-S1 and posterolateral transverse process and intertransverse arthrodesis at L4-L5 and L5-S1. The ___ physician reviewer indicated that the patient has continued to complain of back pain. The ___ physician reviewer noted that the patient has been under the care of a pain management specialist and has been treated with epidural steroid injections and medications. The ___ physician reviewer explained that Botox is FDA approved for conditions involving muscular spasticity or dystonia. The ___ physician reviewer also explained that this patient has continued spasm despite oral medications and repeated epidural steroid injections. The ___ physician reviewer further explained that there are no other surgical or conservative therapies available at this time for the treatment of his condition. Therefore, the ___ physician consultant concluded that the requested Botox R (Botulinuria Toxin Type A) injection to treat refractory myofascial pain and muscle spasms in the lumbar area is medically necessary for the treatment of this patient's condition.

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 8th day of August 2003.