



# Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South • Austin, Texas 78746-5799  
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

## NOTICE OF INDEPENDENT REVIEW DECISION

October 2, 2003

### Requestor

Donald L. Kramer, MD  
Attn: Daniel Garza  
1100 N. Expressway 83, Suite 3  
Brownsville, TX 78521

### Respondent

Texas Mutual Insurance Company  
Attn: Ron Nesbitt  
221 W. 6<sup>th</sup> Street, Suite 300  
Austin, TX 78701

RE: Injured Worker:  
MDR Tracking #: M2-03-1808-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in pain management and anesthesiology which is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient injured her left shoulder and neck on \_\_\_ after she fell at work. She went to see a chiropractor for physical therapy and treatment. The patient was then referred to a pain management specialist with a diagnosis of severe cervicalgia/cervical strain and was placed on prednisone and Ultram medications. A cervical MRI dated 06/11/03 revealed a posterior disc herniation at C4-5 and C5-6 with moderate lateral spinal stenosis.

### Requested Service(s)

Left cervical facet block under fluoroscopic guidance and one week later, a right cervical facet block under fluoroscopic guidance

-----

### Decision

It is determined that the proposed left cervical facet block under fluoroscopic guidance and one week later, a right cervical facet block under fluoroscopic guidance are not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

This patient has chronic neck pain which has not responded to time, medications, including prednisone, and spine rehabilitation. North American Spine Society Guidelines include facet injections at this stage of pain. Medicare guidelines approve facet injections to help identify the source of pain. AHCPR guidelines state "facet injections should be reserved for those who fail to respond to directed conservative care for at least four weeks". This patient meets these guidelines.

However, there is no reason to inject one side first and then second side later. Both sides should be done in the same procedure at the same time. If the patient does not have a significant response, no further injections should be tried. Therefore, it is determined that the proposed left cervical facet block under fluoroscopic guidance and one week later, a right cervical facet block under fluoroscopic guidance are not medically necessary.

This decision by the IRO 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** (10) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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,



Gordon B. Strom, Jr., MD  
Director of Medical Assessment  
GBS:vn

cc: Injured Worker  
Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), 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 2<sup>nd</sup> day of October 2003.

Signature of IRO Employee:

Printed Name of IRO Employee: