December 15, 2003

David Martinez
TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-04-0512-01
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 Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). 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

On ___, ___ attempted to lift an electric motor and suffered a work-related injury in that attempt. She was initially treated at ___ for conservative care at ___ at ___ and at ___. An MRI after the injury was negative except for small Schmoral's nodes. Plain radiographs revealed no fractures. A CT scan suggested facet joint changes at L4/5, at L3/4 and a mild disc protrusion at L5/S1. A myelogram performed four months post injury revealed a small disc protrusion with spondylosis at T11/2 and at L5/S1. However nerve testing suggested L4 radiculopathy. Lumbar discograpy performed on 2/25/02 suggested severe concordant pain at L4-S1, which proceeded to an L4/5 lumbar fusion. It is reported that the patient has not done well with the surgery.

___ had a facet injection done on 4/19/01 and 1/17/03, which would be before and after surgery that was performed on 5/28/02. A CorVel preauthorization request for facet injections was denied, offering the opinion that medial branch blocks may be more appropriate. ___ has authored a letter dated 10/23/03 that this patient is being followed for lumbar radiculopathy, had no motor deficits and was very tender at, above and below the lumbar fusion, aggravated by rotation. He has opined that the findings on the physical examination warranted the necessity for facet injections.

REQUESTED SERVICE

Bilateral facet injections at L3/4, L4/5 and L5/S1 are requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Facet injections typically are a tool as a diagnostic entity in determining pain generators of the lumbar spine. It is unclear the psychosocial aspect of this case regarding this patient's ongoing back pain, but it is clearly recorded in the requestor's notes that pre-operative facet blocks gave absolutely no relief as in a clinic note dated 4/23/01. Approximately eight months post surgery, this patient underwent a second set of facet blocks on 1/17/03, and ___ reports in his clinic note dated 1/29/03 that the facet injection did not help.

It is appreciated the difficulty of diagnosis and treatment of chronic back pain in the non-operative or the operative patient, but it does not appear medically necessary to proceed to a third set of facet blocks when it is clearly documented that the first two sets were ineffective.

Articles to support this review include a "Lumbar Facet Arthropathy" by Carl H. Shin, MD from the Department of Physical Medicine and Rehabilitation, University of Pennsylvania.

___ 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 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

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 15th day of December 2003.