

March 19, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0794-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ 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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. 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 45 year-old female who sustained a work related injury on ___. The patient reported that while at work she attempted to catch a parent who had fainted, when she injured her neck and back. The diagnoses for this patient included cervical and lumbar spine sprain/strain and mild intravertebral disc syndrome of the lumbar spine. Initial treatment for this patient has included medications, physical therapy, and chiropractic treatment. A final report note dated 10/15/02 indicated that the patient reported no pain in the cervical or lumbar spine and the patient was released from care. An update report dated 2/24/03 indicated that the patient was being reevaluated for continued neck pain radiating into the right arm. This note indicated that the diagnoses for this patient included intravertebral disc syndrome secondary to a cervical spine sprain/strain, and a lumbar intravertebral disc syndrome secondary to lumbar sprain/strain. A MRI report of the lumbar spine dated 1/3/03 indicated left subarticular disc protrusion at L4-L5. A MRI report of the cervical spine dated 1/3/03 indicated cervical spondylosis at C5-C6 and C6-C7. An EMG/NCV study report dated 8/26/03 indicated a normal study. An orthopedic evaluation dated 12/1/03 indicated that the diagnoses for this patient included spondylosis NOS. It also indicated that the patient would begin Oxycontin and was referred from cervical and lumbar epidural steroid injections.

Requested Services

Cervical epidural steroid injection at C6-7 and lumbar epidural steroid injection at L5-S1.

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 45 year-old female who sustained a work related injury to her neck and low back on ____. The ___ physician reviewer indicated that the diagnoses for this patient have included cervical and lumbar spine sprain/strain and mild intravertebral disc syndrome of the lumbar spine. The ___ physician reviewer noted that the patient has undergone treatment with medications, physical therapy and chiropractic treatment. The ___ physician reviewer also noted that the patient has undergone evaluations by orthopedics, neurosurgery and pain management. The ___ physician reviewer indicated that the patient continued with neck pain radiating into the right arm and low back and has been recommended to receive epidural steroid injection therapy to the neck and low back. The ___ physician reviewer explained that the patient does not have a surgically correctable process. The ___ physician reviewer noted that the patient has MRI evidence of cervical spondylosis at C5-6 and C6-7 and a disc protrusion at L4-L5. The ___ physician reviewer indicated that the negative EMG/NCV results do not rule out the possibility of significant cervical and lumbar discogenic pain. The ___ physician reviewer explained that the patient has undergone complete evaluations and trials of conservative therapy without significant and prolonged pain relief. The ___ physician reviewer also explained that this patient's continued pain requires a trial of interventional therapy with epidural steroid injections in conjunction with alternative medications to determine if significant or prolonged pain control can be achieved. Therefore, the ___ physician consultant concluded that the requested cervical epidural steroid injection at C6-7 and lumbar epidural steroid injection at L5-S1 are 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/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

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 19th day of March 2004.