

April 28, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1009-01

___ 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 male who sustained a work related injury on ___. The patient reported that while working as a bartender he injured his back. The patient had been evaluated and treated with a course of physical therapy and oral medications. The patient underwent radiographic studies and an MRI of the lumbar spine on 8/27/96 that were reported to have shown no evidence of recent trauma. The patient was also treated with injections followed by physical therapy. A MRI of the lumbar spine dated 10/22/96 showed minimal desiccation at L4-L5 disc greater than L5-S1 disc, without evidence of disc bulge, herniation, central or foraminal stenosis. The patient underwent an MRI of the cervical spine on 2/11/97 that showed degenerative disc changes with secondary spinal stenosis at C6-C7 greater than that at C5-C6. The patient continued with oral medications, physical therapy and on 9/2/98 the patient was prescribed a TENS unit. Beginning 9/17/98 the patient underwent a series of three epidural steroid injections and on 10/27/98 the patient received bilateral sacroiliac joint injections. In 2/99 the patient underwent an intradiscal electrothermal therapy procedure followed by physical therapy, work hardening, and oral medications. The patient began a series of 4 epidural steroid injections on 3/20/01 followed by conservative treatment. The patient is now being referred for another series of epidural steroid injections.

Requested Services

Epidural Steroid Injections

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a male who sustained a work related injury to his back on ____. The ___ physician reviewer indicated that the patient has been evaluated and treated with therapies that have included physical therapy, oral medications, TENS unit, multiple epidural steroid injections, bilateral sacroiliac injections and intradiscal electrothermal therapy. The ___ physician reviewer noted that the patient is continued on oral medication therapy that consists of Oxycontin, Percocet, Robaxin, and Ambien. The ___ physician reviewer indicated that the patient has been referred for further epidural steroid injection therapy. The ___ physician reviewer noted that the patient had received maximal conservative and interventional therapies. The ___ physician reviewer explained that the patient has chronic lumbar pain requiring the use of opioid therapy. However, the ___ physician reviewer also explained that there is no evidence that the patient has participated in a chronic pain management program. Therefore, the ___ physician consultant concluded that the requested epidural steroid injections are not 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 30th day of April 2004.