

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-0073.M2

June 14, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1263-01

___ 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 and is familiar with the condition and treatment options at issue in this appeal. 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 injured his low back while unloading and lifting beer kegs from a truck. A MRI of the lumbar spine performed on 5/22/03 revealed mild edema indentified in the superior end-plates of L5 and S1, and multilevel lumbar spondylosis without evidence of high grade spinal canal stenosis or high grade neural foraminal narrowing identified. The patient underwent an EMG on 11/22/03 that reported no evidence of lumbar radiculopathy and no evidence of neuropathy. Treatment for this patient's condition has included physical therapy, massage therapy, and myofascial injections to the lumbar spine.

Requested Services

One visit of 8 Botox chem injections with EMG guidance

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter from patient received 5/10/04

Documents Submitted by Respondent:

1. MRI report 5/22/03
2. EMG report 11/22/03
3. Designated doctor evaluation 11/14/03

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 41 year-old male who sustained a work related injury to his back on ____. The ___ physician reviewer noted that the patient underwent a MRI of the lumbar spine on 5/22/03 that demonstrated no evidence of spinal canal stenosis, disc herniation, or high grade neural foraminal narrowing. The ___ physician reviewer indicated that an EMG performed on 11/22/03 demonstrated no evidence of lumbar radiculopathy or evidence of neuropathy. The ___ physician reviewer noted that the treatment for this patient's condition has included physical therapy; massage therapy, and myofascial injections. The ___ physician reviewer indicated that there is no documentation that describes how long the patient had been treated with medications or physical therapy. The ___ physician reviewer also noted that the patient had undergone a designated doctor evaluation on 11/14/03 and was assigned a 0% whole person impairment rating. Therefore, the ___ physician consultant concluded that the requested one visit of 8 Botox chem. injections with EMG guidance is 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 14th day of June 2004.