

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-1470-01
IRO Certificate Number: 5259

July 14, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY

There is a dearth of medical records from the provider or the carrier in this case. However, what can be gleaned is that this is a 38 year old lady who fell from a stool while working as a teller. There were complaints of cervical, thoracic, upper extremity and lower extremity pain. Sometime between January 2004 and June 24, 2004 she came under the care of ___. This lady has had cervical ESI, lumbar ESI, imaging of the cervical spine and a physical finding called "facet sign"

was noted. What was not sorted out was the differentiation between the pain associated with the palpation of the lumbar spine myofascial strain and the isolation of a facet joint specific mediated pain response.

Initially ___ recommended lumbar ESI (6/24/04) and physical therapy. There were some hepatotoxicity concerns and this limited the use of some of the medications. There was no indication of any other non-steroidal anti-inflammatory medications or Medrol dose pak to treat the facet problem

REQUESTED SERVICE(S)

Facet Injections at L3-4, L4-5, L5-S1

DECISION

Denied. Endorse pre-authorization findings.

RATIONALE/BASIS FOR DECISION

The diagnosis of facet joint pain has never been made. There were some complaints of pain; however, in light of the disc bulge and the myofascial strain that also had been diagnosed there was no differentiation. In addition, the "shot gun" approach of injecting each structure is not reasonable and necessary care. Additionally, there was no evidence of a trial of non-steroidal anti-inflammatory medications or oral steroid medications in an effort to resolve the symptomology. Moreover, as of May 24, the pain complaints appear to have diminished and that would rule out the facet joints as they had not been treated with injections.

There is no clear clinical indication that the facets joints were part of this injury. Noting that there is significant multiple level disc disease and hypertrophic disease noted on the cervical imaging study, there is a very strong probability that this type of pathology is noted in the lumbar spine. That would indicate that the changes, if any, were a function of an ordinary disease of life and not the compensable event.

Finally, with the medical records presented, and noting that there were a great deal more records that were not forwarded, the requesting provider has not presented us with the competent, objective and independently confirmable medical evidence necessary to ascertain that the injections requested are reasonable and necessary care for the injury sustained.

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) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

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 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

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 15th day of July, 2004.