

November 1, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-0145-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- 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 37 year-old male who sustained a work related injury on ----- . The patient reported that while at work he was assaulted. Treatment for this patient's condition has included oral pain medication. The patient was evaluated by a pain management specialist on 7/26/04 and was recommended for intercostals nerve blocks.

### Requested Services

Intercostal nerve block.

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

#### *Documents Submitted by Requestor:*

1. Letter 8/9/04
2. New Patient Visit 7/26/04

*Documents Submitted by Respondent:*

1. Evaluation 3/1/04
2. Progress Note 3/18/04 – 8/10/04
3. IME 8/3/04

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 37 year-old male who sustained a work related injury to his back on -----. The ----- physician reviewer indicated that the patient complains of localized pain to the left thoracic and left anterior chest region. The ----- physician reviewer noted that the patient underwent x-rays that demonstrated no abnormality. The ----- physician reviewer indicated that the patient continued with complaints of pain. The ----- physician reviewer noted that the patient was initially treated with pain medications and that a pain management specialist has recommended an intercostal nerve block for pain relief. The ---- -- physician reviewer explained that the documentation provided did not demonstrate that the patient had underwent a sustained trial of conservative therapy for pain control. The ----- physician reviewer indicated that the documentation provided did show that the patient experienced relief with medical therapy but that the patient had not undergone any physical therapy, chiropractic care or the use of a TENS unit. The ----- physician reviewer explained that there are medications that can be used on a prolonged basis prior to consideration being given for injection therapy. Therefore, the ----- physician consultant concluded that the requested Intercostal nerve block (CPT 64421) 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,

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State Appeals Department

cc: Texas Workers Compensation Commission

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 1st day of November 2004.

Signature of IRO Employee

Name