

October 22, 2004

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

MDR Tracking #: M2-05-0163-01
IRO #: 5284

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Osteopathy who is board certified in Orthopedics. The reviewer is on the TWCC ADL. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ had low back and right hip pain after a fall on ___, while working for the ___. He slipped while entering a restroom and fell. He states he felt a sharp burning pain on his right hip and back. The pain later worsened and he went to the ___ where he was initially examined and treated by the emergency room doctor.

The records reviewed included:

___ Providers

The issue in dispute is the denial of preauthorization for an outpatient stay to perform an L2 DRG block with possible lesion pulse, pertaining to a ___ injury. In response to the initial request for preauthorization, the physician advisor indicated, "Documentation does not appear to justify block." In response to a request for reconsideration, the physician advisor stated, "Patient with clinical ESS of L4/S1 +/- discogram at L2/3 and L3/4 ... last clinical intimates RSD of the spine ... this is not an indication for DRG block of any kind ... this patient is not an invasive candidate."

3-19-02 through 7-22-04 ___ Office Notes.
2-23-04 MRI
9/29/03 Right L1 and L2 medial branch block by ____.
3/14/03 ___ office notes.
8/5/01 through 5/9/02 office notes and reports from ____.
9/11/01 MRI.

REQUESTED SERVICE

The requested service is a left side DRG block at L2 with possible pulse lesioning.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer indicates that a DRG block is used for both diagnostic measures as well as treatment. The reviewer states it is a minimally invasive procedure. The reviewer notes the decision was based upon the following references.

Pain Physician Vol 4, 2001, Algorithm for Radicular Pain, Somatic Pain and Failed back patient.

Medtronic 2004.

Zani, G. Lowback pain journal American Pharm Association 43:2003.

NIH Guide Volume 26, 2003 Research on Low Back Pain and Common Spinal Disorders.

ACOEM Guidelines, Lowback 1997.

Manchikanti, I Interventional Pain Management Practice Policies, Sympathetic Blocks for peripheral neuropathy, Pain Physician 2001.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy. ___ believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, Texas Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 24th day of October, 2004