

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0262-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. R, MD

January 18, 2005

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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Medical Director

cc:

\_\_\_\_\_  
Dr. R, MD

Rosalinda Lopez, Texas Workers Compensation Commission

#### CLINICAL HISTORY

Records reviewed included:

1. Dr. R notes from 8/1/03 through 9/28/04 (approximately 30 pages);
2. MRI of the right shoulder, impression 9/3/04;
3. \_\_\_\_ impairment rating report; and
4. Dr. H MMI rating report.

42-year-old female with a reported on the job injury on \_\_\_\_\_. She fell to her right shoulder and "did the splits." She has a history of right hamstring avulsion off the ischial tuberosity, right shoulder and leg pain, chronic pain syndrome and facet syndrome.

#### REQUESTED SERVICE(S)

Lumbar facet injections at L3-4, L4-5 and L5-S1.

#### DECISION

Uphold denial.

#### RATIONALE/BASIS FOR DECISION

Facet joint blocks are not an accurate or evidence-based/supported intervention for facet mediated pain. If performed under fluoroscopic and contrast controlled guidance, medial branch blocks are the only peer reviewed, randomized controlled trial supported diagnostic procedure for facetogenic pain. Refer to Drs. L and B's pivotal work in this area.

## 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 14<sup>th</sup> day of January, 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: