

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

**SOAH DOCKET NO. 453-05-7330.M2**

**MEDICAL REVIEW OF TEXAS**

[IRO #5259]

**3402 Vanshire Drive**

**Austin, Texas 78738**

**Phone: 512-402-1400**

**FAX: 512-402-1012**

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

TWCC Case Number:	
MDR Tracking Number:	M2-05-1552-01
Name of Patient:	
Name of URA/Payer:	State Office of Risk Management
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Mario Pena, Jr., MD

May 10, 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,

Michael S. Lifshen, MD  
Medical Director

cc: Mario Pena, Jr., MD  
Texas Workers Compensation Commission

#### CLINICAL HISTORY

This is a 50 year old, 311 pound lady who presented with a complaint of low back pain. This was described as a pressure sensation. There were no radicular complaints. There was tenderness to palpation in the lower lumbar region. Imaging studies completed less than three weeks after the date of injury noted degenerative disc disease, multiple bulging discs and facet hypertrophy. At follow-up, there was some marginal relief with medications and physical therapy. The diagnosis was a sprain/strain type syndrome of the lumbar spine. Subsequent visits noted pain radiating down the leg. In March Dr. Sahinier made the diagnosis of bilateral facet hypertrophy. This assessment was contested by the carrier as being unrelated to the compensable event. Additional assessment were that based on the physical examination reported, the diagnosis of facet syndrome does not exist and it requires more than a finding on imaging studies.

#### REQUESTED SERVICE(S)

Outpatient L4/5 and L5/S1 bilateral lumbar facet medial nerve block.

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

As noted in the ASSIP Guides, injections for this type of syndrome are based on making the diagnosis. There is no pain reported on

extension or lateral bend. Kemp's was not reported out. Given the date of injury and the date of MRI findings of facet hypertrophy; it is clear that the changes noted are not a function of the compensable event. Further, the diagnosis has not been made as there was no indication of facet syndrome based on the physician's physical examination and the physical therapy examination reported. In that she was improving with the physical therapy; and noting the reported mechanism of injury it would seem that this was a myofascial soft tissue injury that is slow to resolve. The requested injections would not alleviate the sequale of the compensable event nor address 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 12<sup>th</sup> day of May 2005.

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

Printed Name of IRO Employee: Cindy Mitchell