MDR Tracking Number: M5-03-0191-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled *Medical Dispute Resolution by Independent Review Organizations*, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that unlisted evaluation and management office visit, established patient office visit, regional IV administering of local anesthesia, fluoroscopic evaluation, supplies and materials and surgical trays were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that unlisted evaluation and management office visit, established patient office visit, regional IV administering of local anesthesia, fluoroscopic evaluation, supplies and materials and surgical trays fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 1/29/02 to 6/25/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 6th day of December 2002.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

November 11, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5 03 0191 01
IRO #: 5251

___ 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 Anesthesiology and who specializes in Pain Management. 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

The claimant in this case was purported to have sustained an injury involving a fall from scaffolding ___. Review from ___ appears to indicate the claimant was evaluated at ___ on 5/28/99 and diagnosis of chest and back contusion was rendered. Reportedly all x-ray were unremarkable. Chiropractic treatment began on 7/30/99. Diagnosis of thoracic sprain, possible cervico-thoraco-lumbar IVD Syndrome without myelopathy; along with Thoracic/Lumbosacral Radiculitis were offered. Chiropractic Manipulative Treatment, Passive Therapy, active exercise along with Work Hardening Program was also implemented. Electro-diagnostics from 8/6/99 suggested right L4 Nerve Root Impairment. Cervical and lumbar MRI studies of 8/26/99 were reported as normal. There was indication of suicide attempt and psychotherapy was recommended and approved. It appears the claimant went on to have multiple interventional pain procedures, including epidural steroid injections, multiple trigger point injections, sacroiliac injections, MBB injections, with no significant improvement. The claimant continued to have evaluation and treatment by ___ through 2002.

REQUESTED SERVICE

Unlisted evaluation and management office visit, established patient office visit, regional IV administration of local anesthesia, fluoroscopy, supplies and materials, surgical trays.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The initial diagnosis does not appear to extend beyond a strain/sprain pattern; with possible exception of the right L4 Radiculopathy which should have responded to appropriately executed selective epidural steroid injections. That not being the case surgical referral or second opinion was warranted. There is not significant documentation in the material reviewed to indicate bilateral Psoas Compartment Block is

reasonable and necessary. Further it is exceptionally apparent that there are significant psychological overtones in this case. It is my opinion that those issues should be addressed above all else at this time.

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.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,