MDR Tracking Number: M5-03-1920-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 17, 2001 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 the facet injections right and left, diskograms, lumbar and repeat diskograms, medical surgical supplies, IV infusion, sterile tray, and anesthesia supply 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 the facet injections right and left, diskograms, lumbar and repeat diskograms, medical surgical supplies, IV infusion, sterile tray, and anesthesia supply 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 6/25/02 to 8/13/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 19th day of August 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-1920-01
IRO Certificate Number: 5259

August 12,2003

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

___ 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 ___.

Sincerely,

CLINICAL HISTORY
This is a male patient, initially reported work injury on ___. He has a history of structural damage to his lumbar spine, lumbar disc disease, disc bulges, and post-surgical spurring. In addition, he has plates

and screws placed at his L5/S1 levels bilaterally. He has EMG evidence of chronic lumbar radiculopathy.

There is no clinical evidence regarding mechanism of injury, no physician notes documenting treatment except for operative report dated 8-13-2002 and progress note dated September 19, 2002.

REQUESTED SERVICE(S)
Facets injections right and left, discograms lumbar and repeat diskograms, medical surgical supplies, IV infusion, sterile tray, anesthesia supply.

DECISION
Agree with carrier for adverse determination.

RATIONALE/BASIS FOR DECISION
In light of the clinical information, there is no obvious need documented to support that the procedures were medically necessary. The procedures performed included in the facet injections of a lumbar spine, and epidurograms. Based on the international spine injection society guidelines, there was no documented evidence to warrant facet injections bilaterally at five levels. The physical examination is never revealed pain on extension or pain with rotation of the lumbar spine, only that there is tenderness on palpation of the muscles over the facet joints.

The epidurograms performed have no place in the routine performance of lumbar facet injections. This is based on national standards, including the international spine injection society standards for facet injections. There is no clinical information to warrant epidurograms as any part of evaluation or treatment in this individual's care.

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.