MDR Tracking Number: M5-03-2587-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution – General 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 dispute was received on June 09, 2003.

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 myelography, injection procedure, localization, supply, CT scan, tomography, surgical trays, needles, infusion, anesthesia for injections procedure, x-ray exams, electrocardiogram, pulmonary studies and unlisted evaluation on 07/02/02 were not medically necessary to treat the patient's condition. 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 fees were the only fees involved in the medical dispute to be resolved. The myelography, injection procedure, localization, supply, CT scan, tomography, surgical trays, needles, infusion, anesthesia for injection procedure, x-ray exams, electrocardiogram, pulmonary studies, and unlisted evaluation on 07/02/02 **were not found to be medically necessary** and reimbursement for dates of service on July 02, 2002 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 10th day of September 2003.

Al Belmarez
Medical Dispute Resolution Officer
Medical Review Division

AB/ab

NOTICE OF INDEPENDENT REVIEW DECISION

August 21, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking # M5-03-2587-01
IRO Certificate # IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This patient had an on the job injury on ___, mechanism unknown. A myelogram and post-myelogram CT scan were performed on 07/02/02.

Requested Service(s)

Myelography, injection procedure, localization, supply, CT scan, tomography, surgical trays, needles, infusion, anesthesia for injection procedure, x-ray exams, electrocardiogram, pulmonary studies, and unlisted evaluation on 07/02/02

Decision

It is determined that the myelography, injection procedure, localization, supply, CT scan, tomography, surgical trays, needles, infusion, anesthesia for injections procedure, x-ray exams, electrocardiogram, pulmonary studies, and unlisted evaluation on 07/02/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical records reviewed contained no documentation pertaining to the patient's extent of injury, past treatments, examination findings, or other diagnostic tests that would provide the medical necessity for the myelogram CT scan performed over three years post-injury. According to the Agency for Health Care Policy and Research Clinical Guideline #14 – Acute Low Back Problems in Adults, US Department of Health and Human Services, December 1994, myelography and CT-myelography are invasive procedures and are indicated only in special situations for pre-operative planning. The medical records reviewed contained no evidence to indicate that the patient had failed a course of conservative care and the records contained no documentation pertaining to past diagnostic imaging studies or surgical consultations.

The records contained no relevant documentation regarding the patient's previous three years of care and no evidence was noted of a surgical consultation. Therefore, it is determined that the myelography, injection procedure, localization, supply, CT scan, tomography, surgical trays, needles, infusion, anesthesia for injections procedure, x-ray exams, electrocardiogram, pulmonary studies, and unlisted evaluation on 07/02/02 were not medically necessary.

Sincerely,