

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 **physical therapy, epidural injection, supplies and office visits were not medically necessary.**

Based on review of the disputed issues within the request, the Division has determined that fees for **physical therapy, epidural injection, supplies and office visits** were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for date of service 5-9-01 through 6-20-01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3rd day of July 2002.

Dee Z. Torres, Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

NOTICE OF INDEPENDENT REVIEW DECISION

June 27, 2002

David Martinez
Chief, Medical Dispute Resolution
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 40
Austin, TX 78704-7491

RE: MDR Tracking #: M5-02-2396-01
IRO Certificate #: 4326

___ 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 §133.308 which allows for medical dispute resolution by an IRO.

___ as 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 ___ physician reviewer who is board certified in anesthesiology, which is the same specialty as the treating physician. The ___ physician reviewer 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 37 year old female sustained an injury to her back on ___ when she was lifting and carrying 10 jackets. Following the injury, the patient underwent physical therapy and low back pain conditioning. The patient underwent lumbar epidural steroid injections, lumbar facet block and lumbar radio-frequency facet denervation in 1997. Most recently, the patient was treated at the ___ between the dates of 05/09/01 and 06/20/01. The treatment included an L5-S1 lumbar epidural steroid injection under fluoroscopy performed on 05/22/01.

Requested Service(s)

Treatment received from the ___ and billed between 05/09/01 and 06/20/01, which included therapy, epidural injection, supplies, and office visits.

Decision

It is determined that the services provided by the ___ and billed between 05/09/01 and 06/20/01 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient had a minor lumbosacral strain injury on ____. She subsequently had years of conservative treatment and rehabilitation. A lumbar MRI performed in November of 1994 was normal, indicating that the patient had suffered no injury to her lower back other than strain. No treatment provided beyond that date was medically necessary. There is no indication for epidural steroid injections, passive modality physical therapy and massage when there was no corroboration of the patient's pain complaints with the objective testing. An epidural steroid injection is not medically indicated when there is a normal MRI regardless of the pain complaint. Physical therapy was not medically necessary 9 years after a lumbar strain injury with no evidence of pathology. Therefore, the services provided by the ___ billed between 05/09/01 and 06/20/01 were not medically indicated.

Sincerely,