

MDR Tracking Number: M5-04-2253-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-22-04.

The Medical Review 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 epidurography radiological supervision and interpretation, unlisted evaluation management service, radiological exam, surgical tray, introduction of needle, supplies for radiological procedures and injections, breathing circuits, gloves, diapers, disposable drug, and introductions rendered on 12/22/03 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 Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for date of service 12/22/03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 10th day of June 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

May 13, 2004

Amended June 2, 2004

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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 care rendered 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy board certified and specialized in Anesthesiology. The reviewer is on the TWCC Approved Doctor List (ADL). 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

This patient was injured at work on ___ when she had an episode of dizziness and fainted, hitting her head. She developed head and neck pain after that time, with radiation into the right shoulder and down the right arm. She continued working through October 2001 and as then taken off work and has remained off work thereafter.

She apparently had an MRI of the cervical spine on 06/05/03 demonstrating no disc herniation or foraminal encroachment. She also had an evoked potential neurologic test by ___ in May 2003, which apparently showed mild C6/7 changes. The reviewer has neither the MRI nor the electrodiagnostic study report available for review.

On 10/16/03, the patient was referred by ___ a chiropractor, to ___ for discography at C4/5, C5/6 and C6/7. On 11/26/03 the patient had a required medical evaluation with ___, an orthopedic surgeon, from which the clinical history and information regarding objective testing was obtained.

On physical exam, the patient had decreased range of motion in the cervical spine in all directions. Her upper extremity sensation was normal, and there was no muscle atrophy, weakness, or reflex changes. ___ diagnosed the patient with fainting spells and dizziness of unknown etiology, as well as cervical strain and head contusion. He stated that the patient did not need further chiropractic treatment and was of being released to work. He stated that the patient did not need pain management or psychiatric care, and that there was no medical documentation of significant damage to any part of her body.

On 11/25/03, the patient apparently had undergone a cervical epidural steroid injection with catheterization by ___ with follow-up on 12/04/03, reporting a reduction in pain from a level of 8 to a level of 6/10. A second cervical epidural steroid injection was performed on 12/22/03, with epidural catheterization, fluoroscopy and a repeat epidurogram. In a letter of medical necessity dated April 14, 2004, ___ stated that the patient's pain level decreased to a level of 4/10 following the second epidural steroid injection.

DISPUTED SERVICES

Under dispute is the medical necessity of epidurography radiological supervision and interpretation, unlisted evaluation management service, radiological exam, surgical tray, introduction of needle, supplies for rad. procedures and injections, breathing circuits, gloves, diapers, disposable drug, introduction rendered on 12/22/03.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

According to the independent medical evaluation report of ___ this patient had no radiologic imaging evidence of disc herniation, nerve root impingement, spinal canal stenosis or epidural fibrosis. Moreover, the patient had no valid electrodiagnostic evidence of radiculopathy as evoked potential studies by ___ in May 2003 do not meet the standard of care, and do not provide valid medical evidence to support any diagnosis, much less radiculopathy. Additionally, the Independent Medical Evaluation documents no physical examination evidence of cervical radiculopathy.

Therefore, in the absence of disc herniation, spinal stenosis, foraminal stenosis, nerve root compression spinal cord compression, epidural fibrosis, physical examination evidence of radiculopathy, and valid electrodiagnostic evidence of radiculopathy, there was, in fact, no medical reason or necessity for epidural steroid injection. Moreover, there was clearly no medical reason or necessity for epidural catheterization in the absence of epidural fibrosis, nor for any of the other items or charges related to the 12/22/03 procedure.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, Inc, dba ___, 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 this finding by US Postal Service to the TWCC.

Sincerely,