

MDR Tracking Number: M5-04-2947-01

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, 133.307 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. This dispute was received on 05-07-04.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

The IRO reviewed an office visit, special reports, injection (betamethsone acetate and betamethsone sodium phosphate, syringe with needle, and arthrocentesis for date of services 1/21/04 that was denied based upon "U".

The office visit, special reports, injection (betamethsone acetate and betamethsone sodium phosphate, syringe with needle, and arthrocentesis for date of services 1/21/04 **were found** to be medically necessary.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 1, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99080-73 was denied by the carrier based on medical necessity. This is a TWCC required report, and is not subject to IRO review. This service is reviewed in accordance with Rule 133.100 (b), and 133.106 (f)(1), and therefore, the requestor is entitled to reimbursement.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 1/21/04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 18th day of August 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

MEDICAL REVIEW OF TEXAS
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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-2947-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

July 27, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports experiencing a low back injury that occurred while at work when lifting heavy plastic spreaders on _____. No previous history of low back pain is documented. The patient underwent several months of conservative care for lumbar sprain/strain conditions with Dr. T, with limited improvement (no specific chiropractic documentation is available for review). The patient also underwent ESI injection to the lumbar spine with a pain management specialist Dr. A on 11/03/03 with no significant improvement of symptoms noted. MRI and EMG studies were found essentially unremarkable. The patient is apparently seen for designated doctor evaluation on 11/25/03 by a Dr. L, but no actual report of this is provided for review. Because of persisting pain and dysfunction, the patient is referred to an orthopedic specialist, Dr. B on 01/21/04. He reports persistent low back pain related to occupational injury that radiates to the right hip and right leg. Provocative examination reveals that the pain generator appears to be the right SI joint rather than lumbar spine. The patient is diagnosed with right SI joint strain and the patient is injected in the right SI joint capsule. SI joint pain is considerably resolved following injection.

REQUESTED SERVICE(S)

Determine medical necessity for office visit, special reports, injection, betamethasone acetate, betamethasone sodium phosphate, syringe with needle, and arthrocentesis for date in dispute 01/21/04.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Documentation suggests that there **is reasonable medical necessity** for orthopedic office visit, reports, injectable medications, syringe and arthrocentesis for date in dispute.

In the clinical practice of chiropractic and orthopedic spine medicine it is common to find a considerable overlay of symptoms and findings when patients present with lower back pain conditions. Without specific clinical work-up and provocative maneuvers it is rather difficult to determine the exact site of pain generation. During acute phases of presentation even the correct diagnostic work-up and provocative evaluation may not reveal the exact site of joint dysfunction and pain origin. Since pain and dysfunction appeared to persist beyond acute phase of presentation, orthopedic specialty consultation did appear reasonably indicated. The result of this specialty consultation did appear to correctly identify point of pain generation, and specific diagnostic/therapeutic injection into the SI joint capsule did appear resolve pain symptoms.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.