

MDR Tracking Number: M5-04-3740-01

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 6-30-04.

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 bilateral radio frequency lesioning of the sacroiliac joints was 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, the request for reimbursement for date of service 7/8/03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 3rd day of November 2004.

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

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3740-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

October 14, 2004

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

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

Records reviewed:

1. Billing summary, medical dispute resolution request/response (10 pages;
2. Dr. C, MD review from 9/22/02;
3. Dr. A, MD myelogram and intra thecal morphine procedure 7/2/03 (2 pages); and
4. Dr. A, MD procedure report 7/8/03 (2 pages).

57-year-old status post lower back injury allegedly while at work on _____. His primary complaint is chronic axial lower back pain without objective neurologic deficit.

REQUESTED SERVICE(S)

Bilateral radio frequency lesioning of the sacroiliac joints.

DECISION

Uphold previous denial.

RATIONALE/BASIS FOR DECISION

The described symptoms and “diagnostic” intra-thecal morphine injection does not diagnose sacroiliac joint arthropathy-arthritis. Please refer to the North American Spine Society Clinical Guidelines. With this lack of a specific diagnosis, radio frequency lesioning of the sacroiliac joints is not appropriate.

Furthermore, radio frequency lesioning of the sacroiliac joints as a pain intervention is not generally supported in the peer reviewed literature. Please refer to *Neural Blockade*, Edited by Michael J. Cousins, MD; 3ed.