

**TEXAS WORKERS' COMPENSATION COMMISSION
MEDICAL REVIEW DIVISION, MS-48
MEDICAL DISPUTE RESOLUTION
FINDINGS AND DECISION**

MDR Tracking Number: M5-05-0429-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 disputed dates of service 3-20-03 and 8-14-03 are untimely and ineligible for review per TWCC Rule 133.308 (e)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. This dispute was received on 9-30-04.

The IRO reviewed office visits, injection (62311), injection (J1030), injection (J2000), and surgical tray (A4550) from 10-29-03 to 11-20-03.

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 \$650.00** 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.

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

ORDER

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 outlined above in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c), 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 dates of service 10-29-03 through 11-20-03 as outlined above.

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 Order is hereby issued this 28th day of January 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 1/25/05

TWCC Case Number:	
MDR Tracking Number:	M5-05-0429-01
Name of Patient:	
Name of URA/Payer:	Carlos J. Garcia, MD
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	Carlos J. Garcia, MD
(Treating or Requesting)	

November 30, 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,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Records reviewed included:

1. Peter M. Garcia, MD review dated 11/4/03 (4 pages);
2. Michael A. Chaplin, DC review dated 2/20/03 (7 pages);
3. Denton Chiropractic Center notes dated 10/5/01 through 3/19/04 (300 pages);
4. Carlos J. Garcia, MD notes and procedures dated 2/03 through 11/03 (20 pages);
5. Lumbar spine MRI dated 12/6/02; and
6. Edward A. Breeding, III, DC Functional Capacity Evaluation dated 2/9/02 (9 pages).

56-year-old female with a work related date of injury of 9/___/01; described as a back injury. The diagnoses have been lumbar degenerative disc disease, lumbalgia, lumbar strain/sprain and radiculopathy.

REQUESTED SERVICE(S)

99213 – Office visit; 62311 – Injection single; J1030 – Injection methylprednisolone; J2000 – Injection lidocaine; A4550 – Surgical trays for dates of service 10/29/03 through 11/20/03.

DECISION

Approve: 99213 – Office visit; 62311 – Injection single; J1030 – Injection methylprednisolone; J2000 – Injection lidocaine; and A4550 – Surgical trays.

RATIONALE/BASIS FOR DECISION

Lumbar facet injections are not an accurate diagnostic intervention according to peer reviewed literature. Refer to Dr. Nicolai Bokduk's et al. work. There are controlled trials supporting dorsal ramus, medial branch blocks to accurately diagnose facetogenic pain. This latter method is the only method accepted by randomized control trial in the literature. Specifically see Dr. Susan Lord's and Dr. Nicolai Bogduk's work.

On the other hand, trochanteric bursitis steroid/anesthetic agent injections are supported by Dr. Aronoff's *Principles and Practice of Pain Management* and in the standard textbook, *Physical Medicine and Rehabilitation*, edited by Dr. Braddom.