

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-03-3619.M2**

May 15, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0930-01
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 proposed care 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 Medical Doctor with a specialty in Occupational Medicine. 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

___ is a 35-year-old female who sustained a work injury on ___ when she tripped over a piece of plywood that as lying on the floor as she was pulling a basket with a 25" television on it. The television fell on the top of her stomach as she fell to the ground, causing pain and discomfort to the neck, back and over the abdomen. She was seen at the ___ emergency room where she was noted to be alert and oriented to person, place and time. She had no evidence of direct head trauma. Her neck was noted to have some decreased range of motion, but she was moving all of her extremities without problems and had no evidence by x-ray of any bony abnormalities of the spine. Her abdomen was noted to be non-tender. The clinical impression at that time was abdominal and back contusion and sprain/strain to the neck and lumbar area. She was noted to have no evidence of any emotional discomfort. She as treated with Toradol and Flexeril.

The patient initiated treatment in ___ with ___ who started physical therapy for three weeks. She was noted to be in discomfort with therapy and had some anxiety. ___ also took her off work for an indefinite period of time. She was placed on a variety of medications but settled into a regiment of Carisprodol, Hydrocodone and Amitriptyline at night. On 10/2/02 she was referred to ___ who performed an EMG, noting that she had no evidence of any lumbar problems and had

muscular symptoms only, with a diagnosis of cervical and lumbar musculoskeletal pain. She was referred for an MRI of the lumbar spine and cervical spine on 10/9/02. The lumbar spine was noted to have a right L4/5 disc protrusion with questionable L4 root involvement. The cervical spine was found to have a C5/6 bulge.

She continued with ___ until 10/16/02. The notes show that she increased her cigarette smoking and eating secondary to anxiety and she continued with pain. At one point, she was given a Handicapped Parking permit and was kept off work for six months. She was depressed and needed to be on Elavil.

The assessment on 11/18/02 was abdominal contusion, resolved; neck pain with no focal neurologic compromise; lumbar pain with no focal neurologic compromise in the lower extremities; posterior axial skeletal muscle pain, tightness, and discomfort due to muscle relaxants and narcotics and a failure to aggressively stretch and strengthen in the immediate post-accident period; psychological stress manifested by anxiety and depression and tobacco use and weight gain secondary to all of the above.

REQUESTED SERVICE

A repeat lumbar MRI, psychological evaluation and payment for medications is requested for this patient.

DECISION

The reviewer both agrees and disagrees with the prior adverse determination.

The reviewer does not find medical necessity for a repeat lumbar MRI. However, the reviewer does find medical necessity for the medications and a psychological evaluation.

BASIS FOR THE DECISION

A review of the medical records shows that ___ had an MRI scan of the lumbar spine without contrast on 10/9/02, and it showed a small right lateral disc protrusion at the L4/5 level potentially involving the right L4 nerve root. Furthermore, she had a myelogram of the lumbar spine on 4/14/03. This showed a diffused broad based bulge at the L4/5 level that mildly flattens the thecal sac. Therefore, in view of the initial MRI scan of the lumbar spine without contrast and the CT scan of the lumbar spine and myelogram, there is no indication for a repeat MRI.

However, the records show that the diagnosis of psychological distress manifested by anxiety and depression was noted on several evaluations. This was noted on the evaluation of 11/18/02, a requested RME at ___. This was also noted on the report of 12/19/02 by ___, M.D. from the ___, and was again noted on the report by ___ dated 2/17/03.

The report by ___ dated 3/5/03 shows that she appears in moderate discomfort and has right paraspinal tenderness, limited range of motion of the lumbar spine, and pain to the back with dorsi-flexion of the ankle. ___ notes that her condition has worsened.

Therefore, based on the medical records available for review, the reviewer finds no documentation to support the medical necessity for the repeat lumbar MRI scan, but does find the psychological evaluation and payment for medications to be necessary for this patient.

___ 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 ___, 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 by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 15th day of May 2003.