

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-0468-01
Name of Patient:	
Name of URA/Payer:	Argonaut Insurance Co.
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Arnulfo T. Carrasco, MD

February 6, 2006

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 the Division of Workers' Compensation 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: Arnulfo T. Carrasco, MD
Division of Workers' Compensation

CLINICAL HISTORY

Records reviewed included:

- Texas Pain Institute; Carrasco Pain Institute; Radiology Associates; Specialty Surgery and Pain Center, and
- Downs*Stanford, PC position correspondence; Intracorp; MRI (5/22/03); EMG; RME (11/22/03); Bernie L. McCaskill, MD Peer Review; Robert E. Holladay, MD Peer Review.

The office records from Dr. Carrasco indicate Mr. _____ was injured on _____, found to have a bulging disc of the lumbar spine with associated discogenic pain. Based on this, he has had complaints of back pain and received series of Botox injections and has been requesting trigger point injections. His physical exam documented includes tenderness across the paraspinal muscles in gluteal region, pain with range of motion documented on July 26, 2005. Plan was trigger point with Toradol.

In January of 2005, he indicates chronic pain in the low back and gluteal region. Physical examination included documented trigger points in that visit and recorded as lumbar and gluteus maximus and gluteus medius in the right more so than the left.

REQUESTED SERVICE(S)

One visit of 4-6 trigger point injections.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Based on individual with an injury back in _____ with what appears to be nothing more than a sprain and strain injury, soft tissue injuries which are generally self limited and improved overtime with or without intervention, although it is not uncommon to provide interventions. Treatment of myofascial trigger points and tender muscles typically

includes rehabilitation program which includes stretching and strengthening as documented in DeLisa's Textbook of Physical Medicine Rehabilitation while the use of trigger points can be effective when noninvasive medical managements are unsuccessful. Treatment as analgesics, passive physical therapy, ultrasound, range of motion, and active exercises is the most reliable method of treatment. Trigger point treatment consists of routine regular stretching to restore the normal resting length of the muscle. Attention to body mechanic stress and daily routines may significantly improve their function. *Back Pain Revolution*, Dr. Waddell reprinted in 2000, states trigger point injections may be considered in an effort to provide temporary reduction of soft tissue symptoms that are of sufficient magnitude as to impede progress with a more aggressive program with therapeutic exercise. In this case, this gentleman has already had more aggressive program with therapeutic exercise. His injury is _____ years old, has been seen inconsistently and irregularly by Dr. Carrasco, and he does not appear to be in any specific impediment to his activities that stretching, therapeutic exercises, and home programs would not correct. He has not shown any lasting benefit from trigger point injections in the past, only short term relief at this state of chronicity in this injury would not be considered necessary.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 8th day of February, 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell