

MDR Tracking Number: M5-03-0385-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 IRO determined the disputed implantation of an electrical stimulator and osteogenesis stimulator of 3/7/02 were medically necessary. 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(q)(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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The disputed surgical procedures were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Finding and Decision is hereby issued this 10th day of December 2002.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

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

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 10th day of December 2002.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/nlb

November 26, 2002

Re: Medical Dispute Resolution
MDR #: M5.03.0385.01
IRO Certificate No.: IRO 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Orthopedic Surgery.

Clinical History:

This 39-year-old claimant was injured, complaining of back pain, on _____. In April 2001, she had lumbar multi-level laminotomies and spine fusion, and placement of a surgically implanted bone growth stimulator.

Continued complaint was felt to be due to pseudoarthrosis (failure of complete fusion) of the bone fusion mass in her lumbar spine. Therefore, on 02/07/02, a second lumbar spine operation was done, which included removal of the bone growth stimulator previously implanted, and removal of internal fixation hardware, excision of the tissue at the area of failed fusion, and exploration of the fusion mass, bilateral laminectomies at multiple levels, and fusion with internal fixation. At a postop visit approximately two weeks following surgery, the use of an external bone stimulator was discussed with the patient, and its need explained. This device was ordered at a month postop.

Disputed Services:

Bone Stimulator.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the equipment in question is medically necessary in this case.

Rationale for Decision:

The surgeon has documented his reasons for recommending an external bone growth stimulator, a device of proven merit in improving the opportunity for bone fusion.

There are at least three distinct indications for the use of this device in this case. The patient, a smoker, has agreed to decrease or stop smoking, and is aware of the increased risk of pseudoarthrosis in persons who smoke. She has had a previous pseudoarthrosis and can be expected to be a greater risk of subsequent fusion mass ossification. In addition, she is HIV-positive, can be expected to have a decreased immuno-inflammatory response capability, and therefore, compromised healing.

Her treating physician has discussed with her the need for the bone stimulator, has demonstrated its use to her in x-rays with it in place, and instructed her in the appropriate use of this device. The reviewer is of the opinion that it is a significantly useful adjunct to the success of surgery in this case.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,