

MDR Tracking Number: M5-03-0494-01

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 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 \$460.00** 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 myofascial releases and therapeutic procedures were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Finding and Decision is hereby issued this 12th day of February 2003.

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 10/16/01 through 11/8/01.

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 12th of February 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/nlb

January 29, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR #: M5-03-0494-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ 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 certified in Chiropractic medicine.

Clinical History:

This 63-year-old female claimant sustained a work-related injury on ____. Onset of pain over the cervical region was immediate and progressively radiated to the shoulder, wrists and hands. She underwent a three-level anterior cervical discectomy and fusion on 01/29/01.

The patient was 9-10 months post surgery when the treating provider performed myofascial release and therapeutic procedures between 10/16/01 and 11/08/01. She completed a chronic pain program in March 2002. The patient continues to have a great deal of pain over the cervical region.

Disputed Services:

Myofascial release and therapeutic procedures from 10/16/01 thru 11/08/01.

Decision:

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

Rationale for Decision:

The patient was progressed through sufficient conservative measures to warrant the application of cervical fusion. Due to a three-level cervical fusion, a change in the current treatment algorithm must be instituted. It appears that a course through a tertiary level of care in March 2002 was unsuccessful.

Persistence of dysfunction and increased severity of symptomatology is seen as a possible result of multi-level fusion surgery. Given the patient's age and the likelihood of dependence on rehabilitative care in life, it become vital to urge active, patient-driven applications.

The aforementioned information was extracted from the following guidelines of practice:

- *Guidelines for Lumbar Fusion (Arthrodesis)*, Washington State Department of Labor and Industries, 2001, June, 6 p.
- *Clinical Practice Guidelines for Non-Malignant Pain Syndrome Patients II: An Evidence-Based Approach*, Journal of Back Musculoskeletal Rehabilitation, 1999, Jan. 1; 1; 13: 47-58 p.
- *Herniated Disc, North American Spine Society Phase III Clinical Guidelines for Multi-Disciplinary Spine Care Specialists*, North American Spine Society, 2000.

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,