

MDR Tracking Number: M5-03-0949-01

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 **or January 1, 2003** 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.

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 treatment/services rendered 8-5-02 to 9-13-02 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these charges.

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 dates of service 8-5-02 through 9-13-02 in this dispute.

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 16th day of June 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

June 13, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0949-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties

referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in neurology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 40 year-old male who sustained a work related injury on ___. This patient has undergone several lumbar laminectomy procedures. The patient underwent a MRI of the lumbar spine on 3/8/95 and a lumbar myelogram on 2/20/96. The patient underwent a lumbar laminectomy on 12/5/94, ALIF 8/10/95 at L4-5 and L5-S1 and a spinal cord stimulator on 4/30/97. The diagnoses for this patient included status post lumbar laminectomy and ALIF at L4-5 and L5-S1 and also spinal cord stimulator implantation and chronic pain syndrome with chronic laminectomy syndrome and fusion syndrome.

Requested Services

RX from 8/5/02 through 9/13/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns 40 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the diagnoses for this patient include status post lumbar laminectomy and ALIF at L4-5 and L5-S1 and also spinal cord stimulator implantation, chronic pain syndrome with chronic laminectomy syndrome and fusion syndrome. The ___ physician reviewer further noted that the patient takes Ultram for pain, and Ditropan and Flomax for neurogenic bladder. The ___ physician reviewer explained that the medications are related to the back injury and subsequent surgery. Therefore, the ___ physician consultant concluded that the prescriptions from 8/5/02 through 9/13/02 were medically necessary to treat this patient's condition.

Sincerely,