

MDR Tracking Number: M5-03-2349-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General 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 dispute was received on 5-19-03.

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(r)(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 pharmacy, medical/surgical supplies, portable x-ray C-arm, anesthesia, and recovery room charges were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The above Findings and Decision are hereby issued this 17<sup>th</sup> day of September 2003.

Dee Z. Torres  
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 6-26-02 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 17th day of September 2003.

David R. Martinez, Manager  
Medical Dispute Resolution  
Medical Review Division

**NOTICE OF INDEPENDENT REVIEW DECISION**

September 8, 2003

**Re: IRO Case # M5-03-2349-01 as amended per TWCC**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery, and who had been admitted to the TWCC Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 45-year-old female who on \_\_\_ injured her back while emptying trash barrels full of books and developed lumbar and lower extremity pain. The pain has varied

between the right and left lower extremities. Physical therapy was unsuccessful in providing relief. A 5/6/99 MRI of the lumbar spine showed a right-sided L5-S1 disk problem. This was not thought to be surgically significant. Epidural steroid injections were of no benefit, and actually increased the patient's back pain. It was noted that the patient soon had neck and shoulder pain also. It was further noted that the patient was 5'8" and weighed 337 pounds. The patient received chiropractic treatment, medications, physical therapy with muscle stimulation and facet joint injections bilaterally at L4-5 and L5-S1 without significant benefit. The facet injections were for 8-10 hours, but the patient never received anything more permanent in that area. Based on the above, the patient underwent laser decompression at the L5-S1 level on 6/26/02

Requested Service(s)

Pharmacy, medical surgical supplies, portable x-ray C-arm, anesthesia, recovery room  
6/26/02

Decision

I disagree with the carrier's decision to deny the requested treatment

Rationale

Although the procedure was not necessary because there was no objective evidence that it might be beneficial based on any studies or examination results that were present at the time of the surgical procedure, the disputed supplies and services from a pharmaceutical and medical standpoint were indicated for the procedure pursued,

While the patient had chronic pain, the only indication (in the records provided) that it might be coming from the L5-S1 inner space was a three-year-old MRI. Without more evidence that the problem was a contained disk, which is necessary for success in pursuing laser decompression, the procedure was not indicated. A post operative MRI suggests continued difficulty at the L5-S1 level.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

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