MDR Tracking Number: M5-03-2738-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution-General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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. This dispute was received on 6-30-03.

The IRO reviewed hot/cold packs from 9-4-02 through 10-22-02.

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 9-11-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ (Max. Allowable Reimbursement) | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 9/4/02 through 10/4/02 | 64999 | $175.00 x 20 days | $0.00 | F | DOP | Rule 133.307(g)(3)(A-F) | Code 64999 is an unlisted surgical procedure code for the nervous system. Relevant information does not support a surgical procedure. No reimbursement recommended. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 11/13/02 | 64450 | $220.00 x 6 = $1,320.00 | $0.00 | Z | $61.00 | | Lumbar facet injection was denied; however, medial branch block w/ minimal to no sedation was recommended. Relevant information supports delivery of service as agreed. Recommend reimbursement of $61.00 x 6 = $366.00 |
| TOTAL | | $4,820.00 | $0.00 | | | | The requestor is entitled to reimbursement of $366.00. |

**ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 for dates of service 9-4-02 through 11-13-02 in this dispute.

This Order is hereby issued this 16th day of April 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

September 4, 2003

MDR Tracking #: M5-03-2738-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in pain management which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating 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 the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient injured his back on ___ while lifting a heavy object. He has had chiropractic treatments, physical therapy, and injection therapy, all of which have helped somewhat. A lumbar MRI revealed facet arthropathy and annular bulging at L3-4 and L4-5. He then had lumbar medial branch neurotomies with moderate pain relief. He began DRX9000 ® treatments on 09/04/02.

Requested Service(s)

Hot or cold packs from 09/04/02 through 11/13/02

Decision

It is determined that the hot or cold packs from 09/04/02 through 11/13/02 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

In reviewing the medical records, this patient had been diagnosed with lumbar sprain/strain and a lumbar herniated disc. He has been treated conservatively with median branch nerve blocks, physical therapy, medications, and chiropractic treatment over a long period of time due to exacerbations following long periods of improvement. He eventually did not get adequate relief from the nerve blocks and the treatment plan changed to include epidural steroid injections. They did relieve his radicular pain but his low back pain continued. The DRX9000 ® treatments were indicated and completed. In addition, the standard of care immediately following these treatments involves the use of hot/cold packs. Therefore, it is determined that the hot or cold packs from 09/04/02 through 11/13/02 were medically necessary.

Sincerely,