MDR Tracking Number: M5-03-3085-01

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, 133.307 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 07-28-03.

The IRO reviewed drugs and supplies, pathology, other services, medical services and surgical services rendered from 08-29-02 through 09-02-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

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

On 12-02-03, 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.

Numerous services rendered on date of service 08-29-02 denied with "F" code. Requestor did not provide documentation to clarify services in dispute or payment rendered by respondent. No additional reimbursement is recommended.

This Finding and Decision is hereby issued this 2nd day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** April 1, 2004

**RE: MDR Tracking #:** M5-03-3085-01
**IRO Certificate #:** 5242

___ 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 Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed 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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery and has an ADL Level 2. The Orthopedic Surgeon 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**
The claimant has a history of chronic back pain allegedly related to a compensable work injury on ___.

**Requested Service(s)**
Drugs and supplies, pathology, other services, medical services, surgical services.

**Decision**
I agree with the insurance carrier that the items in dispute for the dates of service between 8/29/02 through 9/2/02 are not medically necessary.

**Rationale/Basis for Decision**
The claimant was admitted to ___ on 8/29/02 by the treating surgeon for a diagnosis of disc herniations at L4/5 and L5/S1. The admitting physician describes, in addition to herniated lumbar discs, conditions including lateral recessed stenosis, spinal stenosis, and a progressive neurological condition. Generally a clinical work up of a neurocompressive lesion includes electromyogram/nerveconduction velocity studies and a myelogram/CT prior to any consideration of surgical procedure for a clinical diagnosis of lumbar radiculopathy. There is no documentation of electromyogram/nerve conduction velocity studies supporting a diagnosis of lumbar radiculopathy or a corresponding anatomical defect consistent with an isolated neurocompressive lesion that would necessitate any surgery in this clinical setting. There are no objective studies in the documentation provided to support the diagnoses for which the services in dispute were rendered. Due to a complete lack of any clinical documentation supporting these diagnoses, the services rendered from 8/29/02 through 9/2/02 are not deemed to be medically necessary.