

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-0607.M5

MDR Tracking Number: M5-03-2328-01

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 6-4-02.

The IRO reviewed ambulatory surgical center services on 4-2-01.

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 9-3-03, 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
4-2-01	ASC	\$4,791.36	\$2,555.36	M	DOP	1997 ACIHFG and Rule 133.307(g)(3) (A-F)	Relevant documentation was not submitted to support additional reimbursement. No reimbursement recommended.
TOTAL		\$4,791.36	\$2,555.36				The requestor is not entitled to reimbursement.

This Decision is hereby issued this 11<sup>th</sup> day of February 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

### **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 date of service 4-2-01 in this dispute.

This Order is hereby issued this 11th day of February 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

**IRO Certificate #4599**

### **NOTICE OF INDEPENDENT REVIEW DECISION**

August 25, 2003

**Re: IRO Case # M5-02-2328**

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, Rule 133.308 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 Anesthesiology and Pain Management. 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 was injured on \_\_\_, when she slipped and fell off a ladder, striking her neck and back. Her treatment included three epidural steroid injections. The third injection was performed on 4/2/01.

Requested Service(s)

Facility services / supplies 4/2/01

Decision

I disagree with the carrier's decision to deny the requested treatment, except for pre-op time.

Rationale

The third ESI performed on 4/2/01 was reasonable and necessary, as the patient had reported improvement after the first two injections.

The services and supplies provided were necessary except for the charge for pre-op time.

Although the services and supplies were necessary, the charges appear to be excessive. IRO's do not review the appropriateness of fees.

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

Sincerely,