

MDR Tracking Number: M5-02-2547-01

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 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. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

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 office visits on dates of service 5/22/01, 7/27/01, 8/28/01,12/5/01 and the lumbar support pillow billed on 7/24/01 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement charges for the office visits on dates of service 5/22/01, 7/27/01, 8/28/01,12/5/01 and the lumbar support pillow billed on 7/24/01.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
5/22/01 7/27/01 8/28/01 12/5/01 7/24/01	99213 99213 99213 99212 K0113- support pillow	\$75.00 x 3 \$60.00 \$110.00	0.00	U	\$48.00 x 3 \$32.00 x 1 DOP	IRO decision	The IRO determined these office visits and lumbar support pillow was medically necessary. The carrier did not object to fair and reasonable reimbursement, therefore, reimbursement is recommended as billed, amount due: \$48.00 x 3 = \$144.00 \$32.00 x 1 = \$32.00 \$110.00 Total: \$286.00
5/22/01 7/5/01	90782 x 2 J2800 Prilosec Neurontin Orphenadrine	\$40.00 \$75.00 \$139.36 \$112.44 \$149.78	0.00	U		\$40.00 \$75.00 \$139.36 \$112.44 \$149.78	The IRO determined the injections and medication were not medically necessary and therefore not reimbursable.

	Effexor	\$146.01				\$146.01		
	Docusatesod	\$10.11				\$10.11		
	Axocet	\$35.60				\$35.60		
7/24/01	90782 x 2	\$40.00				\$40.00		
	J2800	\$75.00				\$75.00		
7/27/01	90782 x 2	\$40.00				\$40.00		
	J2800	\$75.00				\$75.00		
8/28/01	90782 x 2	\$40.00				\$40.00		
	J2800	\$75.00				\$75.00		
12/5/01	90782 x2	\$40.00				\$40.00		
	J2800	\$75.00				\$75.00		
TOTAL		\$1,563.30					The requestor is entitled to reimbursement of \$286.00.	

On this basis, the total amount recommended for reimbursement (\$286.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$286.00 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 5/22/01 through 12/5/01 in this dispute.

This Order is hereby issued this 19th day of September 2002.

Carol R. Lawrence
 Medical Dispute Resolution Officer
 Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

July 19, 2002

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-02-2547-01
IRO Certificate #: 4326

___ 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 orthopedic surgery 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 35 year old female is under the care of ___ for injuries that she sustained in an accident that occurred at work on ___. The patient injured her lower back as well as her neck. The patient continues to complain of pain and numbness that radiates into the left upper extremities, headaches, and pain to both legs.

Requested Service(s)

Office visits, medications, supplies and injections provided and billed by ___ from 05/22/01 to 12/05/01.

Decision

1. It is determined that office visit (99213) billed for 05/22/01, 07/27/01, 08/28/01 as well as the professional services (99212) billed for 12/05/01 were medically necessary to treat this patient's

condition. In addition, the lumbar support pillow (K0113) billed for 07/24/01 was medically necessary.

2. It is determined that the remainder of the billed services billed between 05/22/01 and 12/04/01 were not medically necessary to treat this patient's condition, including:
 - A. 05/22/01, (90782), (90782), (J2800) Injections of Robaxin.
 - B. 07/05/01, Medications: Prilosec, Neurotin, Orphenadrine, Effexor XR, Docusate Sodium, and Axocet.
 - C. 07/24/01, (90782), (90782), (J2800) injections of Robaxin.
 - D. 07/27/01, (90782), (90782), (J2800) injections of Robaxin.
 - E. 08/28/01, (90782), (90782), (J2800) injections of Robaxin.
 - F. 12/05/01, (90782), (90782), (J2800) injections of Robaxin.

Rationale/Basis for Decision

The patient complained of ongoing symptoms and the professional services provided on 05/22/01, 07/24/01, 07/27/01, 08/28/01 and 12/05/01 were medically necessary in order to evaluate the patient and develop a treatment plan. The Robaxin injections administered during the above office visits were not medically necessary. These injections had been provided in the past and were shown to be ineffective. Therefore, they should not have been continued. The multiple medications provided on 07/05/01 were also found to be ineffective and should not have been continued. The lumbar support pillow provided on 07/24/01 was medically necessary. Lumbar supports have been shown to be symptomatically effective.

Sincerely,