

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: 453-04-7778.M5

MDR Tracking Number: M5-04-1278-01

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 01-07-04.

The IRO reviewed destruction neurolytic agent, office visit, injection Botulinum toxin, normal saline, injection-tendon/ligament, unclassified drug (Myobloc) and injection Triamcinolone rendered on 06-12-03 denied based on "U".

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 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 03-09-04, 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\$	Reference	Rationale
06-12-03	99080-73	\$15.00	\$0.00	U	\$15.00	Rule 133.106(f)	Service was denied with a U code. This is a TWCC required report. Dispute is a fee issue. Reimbursement recommended in the amount of \$15.00.
TOTAL		\$15.00	\$0.00		\$15.00		Requestor is entitled to

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
							reimbursement in the amount of \$15.00

This Decision is hereby issued this 30<sup>th</sup> day of June 2004.

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

**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 Decision is applicable for date of service 06-12-03 in this dispute.

This Order is hereby issued this 30<sup>th</sup> day of June 2004.

Roy Lewis, Supervisor  
 Medical Dispute Resolution  
 Medical Review Division

RL/dlh

June 9, 2004

**CORRECTED REPORT**  
**Corrected spelling errors.**

MDR #: M5-04-1278-01  
 IRO Certificate No.: 5055

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Neurology.

## REVIEWER'S REPORT

### Information Provided for Review:

Correspondence  
H&P and office notes – 1999-2004  
Electromyography reports  
Operative report  
Radiology report

### Clinical History:

This is a 51-year-old female injured on \_\_\_ status post anterior discectomy and fusion performed in 1993 at C5-C6. Postoperative therapy. Some recovery, but continued neck and low back pain. The patient has lumbar disc disease, failed back syndrome, and focal dystonia. She has chronic pain. Botox (Myoblock) injections in the paraspinous muscles have been helpful.

### Disputed Services:

Destruction neurolytic agent, office visits, injection Botulinum toxin, normal saline injection-tendon/ligament, unclassified drug (Myobloc), and injection triamcinolone on 06/12/03.

### Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment, medications and services in disputed as stated above were medically necessary in this case.

### Rationale:

There is more than adequate justification in neurological and pain literature that these are valid, accepted techniques for treatment of chronic pain such as this patient demonstrates judged on these medical records.

Sincerely,