

MDR Tracking Number: M5-04-1625-01

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 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 dispute was received on 2-05-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the myelography, CT L-spine, CT reconstruction, contrast, recovery room, noninvasive ear, fluoroscopic local, x-rays, ECG tracing, anesthesia, surgical trays, infusion, injection needles rendered on 2/20/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for date of service 2/20/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 10th day of May 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION amended 4/23/04
April 26, 2004

Re: IRO Case # M5-04-1625

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, Rule133.308 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 Neurologic Surgery and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. 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 is a 36-year-old male who in ___ was loading some 50 pound steel "cut offs" and developed back pain. The pain became gradually worse with work. The patient eventually went to the ER and a diagnosis of neck sprain was made. The patient was referred to a physician. Because of continuing pain, an MRI of the lumbar spine was performed on 1/31/02. The MRI showed bulging disks with no surgically significant disk herniation. Physical therapy was ordered. The patient also had some neck pain. An MRI of the cervical spine on 2/21/02 showed some bulging disks, but no significant pathology, except for the rather elevated amount of chronic change for his age. A 3/4/02 EMG showed bilateral L5 root problems potentially present.

Requested Service(s)

Myelography, CT L spine, CT reconstruction, contrast, recovery room, Noninvas ear, fluoroscopic local, x-ray, ECG tracing, anesth, surgical trays, infus, inj needles
2/20/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

There is nothing in the records that were provided for this review that would indicate changes in the patient's findings or status before the CT myelogram was ordered. Nothing was provided that suggested a surgical circumstance, and therefore myelographic evaluation was not indicated. Myelography is an invasive surgical procedure with some possible complications, and it is strictly diagnostic and not therapeutic. Therefore, it should not be pursued unless surgery potential is anticipated. In addition, there was no change in the patient's examination or symptoms between the MRI and various other tests, and the CT myelogram.

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