

MDR Tracking Number: M5-04-2213-01

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 (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 March 19, 2004

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The IRO reviewed the CAT of the lumbar spine, injection procedure-myelography, CT coronal sagittal multiple, myelography lumbosacral, supply of low osmolar contrast, unlisted evaluation and management services, surgical trays, infusion of normal saline solution, noninvasive ear/pulse oximeter, fluoroscopic localized needle BX/FI, Rad Exam Spine Lumbosacral, ECG-Routine ECG W/12 leads, injection of Diazepam, injection of Metoclopramide HCL, injection Fentanyl Citrate, Injection Lidocaine, needles only, sterile, and Anesthesia injection procedure myelography and **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on the 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 June 25, 2004 the Medical Review Division submitted a Notice to the 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.

CPT code 72114-WP-rendered on 04-30-03. Review of the requestors' and respondents' documentation revealed that neither party submitted copies of EOB's or HCFA's. Relevant information to support delivery of service was not submitted by the requestor therefore, no reimbursement recommended.

Therefore, the Commission declines to issue an order in this dispute.

The Decision is hereby issued this 30th day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

June 17, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48

Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-2213-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 TMF physician reviewer who is board certified in Orthopedic Surgery which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1978. The TMF 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 TMF 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 patient sustained a work-related injury on ___ when he fell while working on a pallet and struck his lower back. The patient complains of lower back pain radiating to his left leg associated with numbness and tingling in the L4 through S1 distribution, primarily at L4-S1 associated with weakness. Medical records indicate that the patient underwent a lumbar myelogram on 04/30/03 and that all procedures and equipment associated with the myelogram were denied.

Requested Service(s)

CAT of the lumbar spine, Injection procedure-myelography, CT coronal sagittal multiple, myelography lumbosacral, supply of low osmolar contrast, unlisted evaluation and management service, surgical trays, infusion of normal saline solution, noninvasive ear/pulse oximeter, fluoroscopic localized needle BX/FI, Rad Exam Spine Lumbosacral, ECG-Routine ECG W/12 leads, injection of Diazepam, injection of Metoclopramide HCL, injection Fentanyl Citrate, injection Lidocaine, needles only, sterile, Anesthesia injection procedure myelography

Decision

It is determined that the CAT of the lumbar spine, Injection procedure-myelography, CT coronal sagittal multiple, myelography lumbosacral, supply of low osmolar contrast, unlisted evaluation and management service, surgical trays, infusion of normal saline solution, noninvasive ear/pulse oximeter, fluoroscopic localized needle BX/FI, Rad Exam Spine Lumbosacral, ECG-Routine ECG W/12 leads, injection of Diazepam, injection of Metoclopramide HCL, injection Fentanyl Citrate, injection Lidocaine, needles only, sterile, and anesthesia injection procedure myelography were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

All of the disputed expenses are related to a lumbar myelogram performed more than one year after surgery to the lumbo-sacral spine due to an injury suffered in a fall. The medical record documentation does not contain findings suggestive of root compression. Thus, the documentation fails to substantiate the medical necessity for the myelogram performed on 04/30/03. Since the lumbar myelogram was not medically indicated, the expenses related to the myelogram were not medically necessary.

Sincerely,