



Texas Department of Insurance, Division of Workers' Compensation
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address:

Texas Back Institute
 P.O. Box 262409
 Plano, TX 75026

MDR Tracking No.: M5-06-1616-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Texas Mutual Insurance Company, Box 54

Date of Injury:

Employer's Name: Quality Plumbing and Electric

Insurance Carrier's No.: 99B0000301711

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Co surgeon was not used for this procedure."

Principle documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500
3. EOB

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

Principle documentation:

1. DWC-60/Table of Disputed Service

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-28-05	CPT code 22558-80	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$300.97
	Grand total		\$300.97

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and Respondent.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did prevail on the disputed medical necessity issues. The amount due the Requestor for the items denied for medical necessity is \$300.97.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1)

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the carrier must refund the amount of the IRO fee (\$460.00) to the Requestor within 30 days of receipt of this order. The Division has determined that the Requestor is entitled to additional reimbursement in the amount of \$300.97. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

Authorized Signature

Typed Name

8-11-06

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

NOTICE OF INDEPENDENT REVIEW DECISION

June 28, 2006

Amended Letter: August 3, 2006

Program Administrator
Medical Review Division
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #:
Injured Worker:
MDR Tracking #: M5-06-1616-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC §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 1969. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO. 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 ____ resulting in injury to his lower back. A percutaneous procedure was performed in 2003 that failed. An anterior partial corpectomy and interbody procedure was performed on 09/28/05.

Requested Service(s)

CPT Code 22558-80 (Arthrodesis – lumbar) provided on 09/28/05

Decision

It is determined that the CPT Code 22558-80 (Arthrodesis – lumbar) provided on 09/28/05 was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The percutaneous procedure performed on this patient failed to provide relief. A pre-operative evaluation included flexion/extension lateral x-rays of the lumbar/sacral spine that documented translation of L5 on S1. Discography confirmed L5/S1 as pain generators. An anterior discectomy was planned and performed. Anterior interbody arthrodesis is an integral part of this surgical procedure and was medically necessary and appropriate. Surgical exposure for the procedure is commonly performed by general surgeons who are more familiar with the anatomy anterior to the lumbar spine.

This decision by the IRO is deemed to be a DWC decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

Information Submitted to TMF for Review

Patient Name: ____ **Tracking #:** M5-06-1616-01

Information Submitted by Requestor:

- **Table of Disputed Services**
- **Letter of Medical Dispute**
- **Claims**

- **Operative Reports**
- **Letter from Texas Mutual**
- **Letter from Texas Back Institute**
- **Office notes from Dr. Roybal**
- **Office notes from Dr. Rashbaum**
- **History and Physical**
- **Intra-operative Neuro-physiological monitoring report**
- **Radiological report of the CT of the spine**
- **Report of lumbar discogram**
- **Report of the MRI of the lumbar spine**
- **Report of the x-ray of the eye**

Information Submitted by Respondent:

None