

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.

Per review of Box 32 on CMS-1500, zip code 78705 is located in Travis County. The maximum reimbursement amount, under Rule 134.202(c)(1), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §134.1, §133.308 and §134.202
Subchapter G, Chapter 2001, Texas Government Code

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 Division has determined that the Requestor is entitled to reimbursement in the amount of \$2,336.85. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$650.00. The Division hereby **ORDERS** the Respondent to remit this amount per Division Rule 134.130 plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Order :

02-04-08

Authorized Signature

Medical Dispute Resolution Officer

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

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

CompPartners



Notice of Independent Review Decision

SENT TO: Texas Department of Insurance
Health & Workers' Compensation Network Certification and QA Division (HWCN) MC 103-5A
Via E-mail IRODecisions@tdi.state.tx.us

Spine and Rehab Center
Jodi Atchley
Fax: 512-343-7113
Phone: 512-345-5925 x 248

TSP Joint Self Ins Funds
Harris & Harris/Mark Sickles
Fax: 214-754-0524
Phone: 214-954-1530

1/4/08

Amended Date: 1/16/08

RE: MDR Tracking #: **M5-08-0062-01**
Name:
Coverage Type: Workers' Compensation Health Care (Non-network)
Type of Review:
 Preauthorization or Concurrent Review
 Retrospective Review

CompPartners has been certified, certification number **5298**, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to the IRO for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

The IRO has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, the IRO reviewed the medical records and documentation provided to the IRO by involved parties.

This case was reviewed by a **Texas Licensed Orthopedic Surgeon**. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of **CompPartners** I certify that:

1. There is no known conflict between the reviewer, the IRO and/or any officer/ employee of the IRO with any person or entity that is a party to the dispute, and

2. a copy of this IRO decision was sent to all of the parties via U.S. Postal Service or otherwise transmitted in the manner indicated above on **1/4/08 and 1/16/08**.
3. The independent review was performed by a health care provider licensed to practice in Texas.

Right to Appeal

Effective September 1, 2007, there have been statutory changes to the appeals process which is currently pending rule changes. For information regarding the new appeals process, please contact the Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P. O. Box 17787, Austin, Texas, 78744, 1-800-252-7031, 512-804-4038, or 512-804-4075.

Spinal Surgery Only

For disputes related to *prospective or concurrent review of spinal surgery*, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for a CCH must be in writing and received by the Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P. O. Box 17787, Austin, Texas, 78744, within ten (10) days of your receipt of this decision.

Sincerely,

Lee-Anne Strang
Senior Supervisor
CompPartners

IRO REVIEWER REPORT

DATE OF REVIEW: 1/4/08

DATE AMENDED: 1/16/08

IRO CASE #: M5-08-0062-01

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical necessity for lumbar laminectomy at L5-S1.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas certified Orthopedic Surgeon.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- X Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- **Transmission Ok dated 12/4/07.**
- **Notification of IRO Assignment dated 12/4/07.**
- **Revised Notification of IRO Assignment dated 12/27/07.**
- **In Receipt of Request for Medical Dispute Resolution Report/Letter dated 8/31/06.**
- **Table of Disputed Services dated 8/31/06.**
- **Fax Cover Sheet Comments dated 12/18/07, 1/30/07.**
- **Explanation of Worker's Compensation Payments dated 8/31/06.**
- **In Regards to this Medical Necessity Dispute Report/Letter dated 12/28/07.**
- **Response to the Medical Dispute filed by Requestor dated 2/13/07.**
- **Health Insurance Claim Form dated 8/31/06.**
- **New Patient Evaluation dated 8/22/06.**
- **Lumbar Spine MRI dated 8/25/06.**
- **Medical Dispute Resolution Request/Response (unspecified date).**
- **Provider's Information (unspecified date).**

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: 32 years

Gender: Male

Date of Injury:

Mechanism of Injury: Playing volleyball as a probation officer.

Diagnosis: Herniated L4-5.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The patient is a 32-year-old male with a date of injury of [redacted]. The mechanism of the injury was playing volleyball as a probation officer. The diagnosis is herniated L4-L5. The patient was seen after hours of clinic and started on medication. The patient was referred to Dr. Mal's office, and there he was seen by a physician assistant, prescribed pain medication, muscle relaxants, and told to return to work. When the back became more severe, X-rays were taken. The patient had a prior injury five to six years previously, but after conservative care, the pain resolved with no complaints until this episode. The patient was referred to Dr. Tipton's office around August 22, 2006, when he was evaluated, complaining of low back pain radiating into the left buttock, posterior thigh, and calf. The patient was noted on physical examination, flexion extremely limited with reproduction of low back pain. There was tenderness at L4-L5 and L5-S1, minimal in nature and in the upper left buttocks. Extension was without difficulty. Reflexes were 2+ symmetrical. Sensation was intact. Heel and toe walking was unremarkable, and straight leg raising on the left reproduced low back pain. At that time, the patient was started on physical therapy and Celebrex, and was to continue to work full duty. The patient was noted to have the August 25, 2006 MRI reviewed that revealed a large central disk herniation more prominently toward the left, compressing the entire thecal sac and with potential encroach upon any other roots at L5 and below. The patient then had a severe progression of his symptomatology, according to the Dr. Tipton in a case discussion, with progressive extensor hallucinus longus (EHL) weakness and pain to such a severe amount the patient had to be in a wheelchair. He admitted the patient for pain control due to the severe nature and progression of the pain with such significant limitation on the patient's ability to function. Then with the ongoing worsening of the EHL weakness due to the large size of the disk rupture, Dr. Tipton was concerned about an impending cauda equina syndrome, and therefore took the patient to surgery where the L4-L5 laminectomy discectomy was performed. Dr. Tipton indicated that after the surgical intervention, the patient had a routine recovery and he was not seeing the patient since dismissal from the postoperative care of the surgical procedure. The rationale for full certification of the laminectomy discectomy is the patient meets the ODG indications in that there was severe unilateral dorsiflexor weakness. There was an extremely large disk rupture at L4-L5 noted on MRI. The patient had been tried with physical therapy, NSAIDs, and pain medication. The patient only did not meet the greater than two month activity modification and the nature of this injury with the severe progression of the focal neurological deficit. This reviewer feels this was an indication for the emergent surgical intervention for possible cauda equina. If there is a question as to hospitalization, the patient was a candidate for hospitalization for acute back pain with the patient having neurological findings suspected to be acute or progressive. The Official Disability Guidelines state that if a patient has a new or progressive neurological deficit, he or she may be hospitalized in order to facilitate surgical decision-making to provide close observation for further progression or to help the patient compensate for neurological deficits. The only valid reason for hospitalization is that he or she cannot manage basic activities of daily living (ADLs) at home, which Dr. Tipton indicated it was a case for this patient. Therefore, this reviewer feels that this does meet ODG criteria in all aspects except for the activity modification greater than two months and this is medicine outlier due to the emergent nature of the patient's progression of physical findings and large herniated disk findings on him.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)