MDR Tracking Number: M5-03-1842-01

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 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 3-20-03.

The IRO reviewed an unlisted anesthesia procedure rendered on 4-17-02.

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

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

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 13, 2003, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
4/17/02	72295	462.00 x 2	0.00	F	462.00	96 MFG RAD. GR and CPT descriptor	Radiological report/interpretation was not submitted to support services rendered. No reimbursement recommended.
4/17/02	A4649 A4649 A4649 A4649 99070 A4649 A4649 A4649 A4209 A4215 A4649 A4649 A4245 A4649 A4649	30.00 25.00 30.00 32.00 7.50 1.50 3.00 3.00 10.00 44.00 250.00 132.00 5.00 25.00 25.00	0.00	G, 20	DOP	96 MFG DME GR; HCPCS codes	Supplies are not global to primary procedure. Recommend reimbursement of $665.00.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
	99070 A4615 A4454 A4649 A4649 A4649	1.50 1.50 6.00 10.00 3.00 20.00					
TOTAL		665.00	0.00				The requestor is entitled to reimbursement of **$665.00.**

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 Order is applicable for date of service 4-17-02 in this dispute.

This Order is hereby issued this 12th day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
DZT/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

June 4, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-1842-01
IRO Certificate #: IRO4326

___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 ___ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

___ 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 ___ physician reviewer who is board certified in pain management which is the same specialty as the treating physician. The ___ 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 ___ 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
There was no documentation presented regarding the events of this patient's back injury on ___. The procedure performed was a three level discography with IV sedation.

Requested Service(s)
An unlisted anesthesia procedure

Decision
It is determined that the unlisted anesthesia procedure was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
There were no medical records available to support medical necessity of a medical procedure. The only documentation was a letter of appeal for a three level discogram and IV sedation and a report of the procedure. There were no physical exam notes, imaging results, previous treatment modalities tried, or subjective complaints from the patient. Therefore, it is determined that the unlisted anesthesia procedure was not medically necessary.

Sincerely,