MDR Tracking Number: M5-03-1982-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 2-24-03.

The IRO reviewed a three-dimensional reconstruction rendered on 5-7-02 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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

Based on 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 July 15, 2003, the Medical Review Division submitted a Notice to 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
5-7-02	A4644 - Omnipaque	350.00	25.00	M	DOP	MFG DME GR IV, Radiology GR II B, Rule 413.011(d)	Operative report and "Myelogram without anesthesia" supply list supports services rendered. Commission Rule 133.304(I)(1-4) places certain provisions on the carrier when reducing the billed amount to fair and reasonable. Per carrier's response dated 4-11-03, the carrier reevaluated their payment methodology and recommended an additional $23.00 plus interest. Per Rule 413.011(d), the requestor submitted redacted EOBs to support charges for

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
							same/similar procedure @ $150.00 and carrier reimbursement @ $150.00. Therefore, recommend additional reimbursement of $102.00.
5-7-02	99070-ST 99499-RR	237.11 $119.00	0.00 0.00	G	DOP	MFG Radiology GR I A 1-4	Operative report indicates procedure as lumbar myelogram w/ post myelogram CT scan. Per EOB, the requestor billed for whole procedure (-WP). In the Radiology Ground Rules, whole procedure includes professional component and technical component. The technical component includes such items as materials, space, equipment, and other facility resources. Therefore, sterile tray charges and recovery room charges are global to the primary service. No additional reimbursement recommended.
TOTAL		706.11	25.00				The requestor is entitled to reimbursement of $102.00.

This Decision is hereby issued this 18th day of December 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

July 8, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1982-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified neurosurgeon. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. As part of her treatment plan, the patient underwent a lumbar myeolgram on 5/7/02 followed by a 3-D reconstruction CT scan.

Requested Services

The three dimensional reconstruction CT (CPT Code 76375) performed on 5/7/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her lumbar back on ___. The ___ physician reviewer also noted that as part of the treatment plan for this patient, she underwent a lumbar myeologram on 5/7/02 followed by a 3-D reconstruction CT scan. The ___ physician reviewer explained that although a 3-D CT reconstruction is without proven value in diagnoses and treatment of this patient condition. The ___ physician reviewer also explained that the rational for usage in this case is unclear. Therefore, the ___ physician consultant concluded that the three dimensional reconstruction CT scan (CPT Code 76375) on 5/7/02 was not medically necessary to treat this patient's condition.

Sincerely,