MDR Tracking Number: M5-02-2190-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for dates of service 5/1/01 (CPT code 61712) and 5/31/01 (CPT code 99214).

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity for dates of service 5/1/01 and 6/28/01. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for 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 the only issue to be resolved. The laminectomy/diskectomy and impairment evaluation were found to be medically necessary. The respondent raised no other reasons for denying reimbursement charges for the laminectomy/diskectomy and impairment evaluation.

This Finding and Decision is hereby issued this 14th day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 to dates of service 5/1/01 and 6/28/01 in this dispute and IRO fee.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 14th day of October 2002.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/crl

October 9, 2002

Re: Medical Dispute Resolution
MDR #: M5.02.2190.01
IRO Certificate No.: IRO 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. A physician who is Board Certified in Orthopedics and Spine reviewed your case.

The physician reviewer **PARTIALLY AGREES** with the determination of the insurance carrier in this case. The reviewer is of the opinion that the Laminectomy and Diskectomy on 05.01.01, and the evaluation of medical impairment on 06.28.01 **WERE MEDICALLY NECESSARY**. The Macroscopic Dissection on 05.01.01 and follow-up office visit on 05.31.01 **WERE NOT MEDICALLY NECESSARY.**

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning MDR #M5-02-2190-01, in the area of Spine Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of emergency surgery (lumbar laminectomy, diskectomy, microscopic excision of free fragment, decompression) and office visits from 5/01/01 through 6/28/01.
2. Correspondence.
3. History and physical and office notes.
4. Operative note.
5. Radiology report.

B. BRIEF CLINICAL HISTORY:

The patient was injured on ___ while working on the job. The patient was admitted to the emergency room. The patient underwent an MRI on 4/20/01, with the finding of right-sided disk herniation. The patient was admitted to the hospital on 4/30/01, and two separate physicians' exams confirmed foot-drop on the right as well as absent ankle jerks.

C. DISPUTED SERVICES:

1. CPT Code 63030 - Laminectomy and diskectomy.
2. CPT Code 61712 - Microscopic dissection.
3. CPT Code 99214 - Follow-up office visit.
4. CPT Code 99455 - Evaluation for medical impairment.

D. DECISION:

I PARTIALLY AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE. IN MY OPINION, THE LAMINECTOMY AND DISKECTOMY ON 5/01/01, AND THE EVALUATION OF MEDICAL IMPAIRMENT ON 6/28/01 WERE MEDICALLY NECESSARY. MICROSCOPIC DISSECTION ON 5/01/01 AND THE FOLLOW-UP OFFICE VISIT ON 5/31/01 WERE NOT MEDICALLY NECESSARY.

E. RATIONALE OR BASIS FOR DECISION:

CPT Code 63030 should not be denied because the patient does have MRI confirmation of a large disk herniation and two separate physicians' examinations indicating neurologic deficit present five weeks after this injury.

I do agree that Code 61712 should be denied, for two reasons: (1) This code is no longer used; 69990 is presently used for the use of an operating microscope, and review of the operative note indicates no operating microscope was used.

CPT Code 99214 should also be denied because it falls within the global period of 63030.

CPT Code 99455 should not be denied, as this was an evaluation for maximum medical improvement.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

I certify that I have no past or present relationship with the patient and no significant past or present relationship with the attending physician. I further certify that there is no professional, familial, financial, or other affiliation, relationship, or interest with the developer or manufacturer of the principal drug, device, procedure, or other treatment being recommended for the patient whose treatment is the subject of this review. Any affiliation that I may have with this insurance carrier, or as a participating provider in this insurance carrier's network, at no time constitutes more than 10% of my gross annual income.

Date: 4 October 2002