

**MDR Tracking Number: M5-04-2819-01**

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 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 dispute was received on 4-30-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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

The sterile gloves, variable concentration mask, breathing circuits, supply of radiopharmaceutical diagnostic imaging agent-not otherwise specified, for 10-31-03 **were found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute 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 7-14-04 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.

On 11-2-04 the requester withdrew HCPCs codes J7070, J2405, J1094, J1885, J0704 and J2000 for 10-31-03.

CPT Code 99499-59 was denied by the carrier with an "F" denial code even after the requestor recoded the requested service. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. Per 134.202 (c) 6 for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount, the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission

medical dispute decision, and values assigned for services involving similar work and resource commitments. **Reimbursement is recommended.**

CPT Code 72275-59 was denied with a “G” denial code. According to Rule 133.304 (c) and 134.202(a)(4) the insurance carrier must state what the service is global to.

**Recommend reimbursement of \$92.00.**

HCPCs codes A4550 and A4305 were denied by the carrier with “G” denial codes. According to Rule 133.304 (c) and 134.202(a)(4) the insurance carrier must state what the service is global to.

Per Rule 133.307(g)(3)(D), the requestor is also required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The requestor has not provided sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **Recommend no reimbursement.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(c); in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c)(6); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 10-31-03 as outlined above in this dispute.

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 Decision and Order is hereby issued this 4<sup>th</sup> day of November, 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

## **MEDICAL REVIEW OF TEXAS**

**[IRO #5259]**

**3402 Vanshire Drive  
Phone: 512-402-1400**

**Austin, Texas 78738  
FAX: 512-402-1012**

## **NOTICE OF INDEPENDENT REVIEW DETERMINATION**

TWCC Case Number:
MDR Tracking Number: M5-04-2819-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

July 8, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Files reviewed: Office notes were reviewed from 8/19/03 through 4/28/04, in chronological order; Procedure note dated 10/31/03 (service dispute date); Electrodiagnostic exam by Dr. D on 10/9/03;

Case summary by Texas Mutual; and MRI of the lumbar spine dated 9/5/03. Male status-post fall from a ladder on \_\_\_ with multiple injuries. He underwent L4-5 epidural steroid injection.

REQUESTED SERVICE(S)

A4930 pair of sterile gloves, A4620 variable concentration mask, A4618 breathing circuits, A4641 supply of radiopharmaceutical diagnostic imaging agent not otherwise specified for date of service 10/31/03.

DECISION

Reverse prior denial. Approve.

RATIONALE/BASIS FOR DECISION

According to the care standards as outlined by the International Spinal Injection Society (ISIS) templates, the aforesated materials are reasonable and necessary.