

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 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 7-28-02.

The IRO reviewed inpatient hospital charges from 8-15-02 through 8-23-02.

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.

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

On 12-31-03, 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.

A review of the medical records submitted for review indicated the following:

The requestor billed \$5,720.00 for room and board. The respondent paid \$8,944.00 with denial codes "F" and "M". The requestor billed \$474.39 for inhalation service, \$734.57 for pulmonary function, \$733.21 for cardiology, and \$5980.00 for recovery room charges. The respondent paid \$0.00.

(Medical necessity portion is stop-loss)

The Requestor submitted History and Physical Exam, Operative Report, redacted SOAH decision pertaining to pain management services, and a redacted SOAH decision pertaining to an ASC dispute. The Requestor did not provide relevant documentation in accordance with the criteria of the Texas Labor Code §413.011 (b) to support a need for a change in the reimbursement. Specifically, the Requestor did not submit a sampling of documentation reflecting the fair and reasonable amount paid by other carriers for same or similar services. Based on the submitted documentation, the Requestor has not met the requirements identified in Rule 133.307(g)(3)(B) and the Texas Labor Code §413.011 (b). Therefore, the Requestor is not entitled to additional reimbursement for inpatient hospital charges.

This Decision is hereby issued this 17th day of February 2004.

Medical Dispute Resolution Officer
Medical Review Division

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 dates of service 8-15-02 through 8-23-02 in this dispute.

This Order is hereby issued this 17th day of February 2004.

Manager
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-0041-01
Name of Patient:	
Name of URA/Payer:	Vista Medical Center Hospital
Name of Provider: (ER, Hospital, or Other Facility)	Vista Medical Center Hospital
Name of Physician: (Treating or Requesting)	Eric Scheffey, MD

December 22, 2003

An independent review of the above-referenced case has been completed by a neurosurgeon physician. 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,

Michael S. Lifshen, MD
Medical Director

cc: Florist Mutual c/o Crawford & Co.
Eric Scheffey, MD
Texas Workers Compensation Commission

CLINICAL HISTORY

The patient is a 50-year-old white female who sustained an injury to her back on 4/____/99. She was treated with IDET L3-4, 4-5 and L5-S1 without improvement. She then underwent posterior fusion at L3-S1 on 4/25/01 with instrumentation. At some point a bone fusion stimulator was implanted. She did well initially but subsequently developed recurrent back pain. Myelogram and CT myelogram 1/02 showed possible multiple areas of pseudoarthrosis with additional stenosis at L2-3. She was subsequently approved for revision surgery which was performed. Payment is being refused.

REQUESTED SERVICE(S)

EBI Removal, excision of cyst, hardware removal, exploration of fusion mass, excision of pseudoarthrosis, harvesting autograft, laminectomy with

foramenotomies L1-S2, fusion and instrumentation with complex wound closure.

DECISION

Approved. The performed services were certainly medically necessary as part of the surgical procedure.

RATIONALE/BASIS FOR DECISION

This was a complicated revision surgery and the surgeon in question was very thorough in the description of operative findings and rationale for different portions of the procedure. Removal of the EBI was necessary for obvious reasons as was closure of the pocket around the pulse generator. Decompression of the compressed nerve roots was necessary for obvious reasons. Hardware removal was necessary for fusion assessment. Pseudoarthrosis repair requires resection of the unhealed segment and placement of new graft. To prevent recurrence of pseudoarthrosis autograft should be used and instrumentation should be re-applied. Interbody fusion at L2-3 was appropriate to increase fusion rate and prevent further pseudoarthrosis. With revision surgery, previous scarring can make wound closure difficult necessitating the use of local muscle flaps for elimination of dead space and prevention of infection which would be a disaster in this patient.