MDR Tracking Number: M5-03-3174-01

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 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 08-05-03.

The IRO reviewed hospital charges including room/board, pharmacy, medical surgical supplies, sterile supply, laboratory, x-ray, x-ray/other, anesthesia and emergency room rendered on 08-19-02 that was denied based upon “V”.

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.

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 10-21-03, 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.

Dates of service 8-20-02 and 8-21-02 were not clarified by the requestor and relevant information was not submitted to support delivery of service. No reimbursement recommended.

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

DOS	REV CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
8-19-02	120	$1,430.00	$0.00	M	Fair and Reasonable	Rule 133.307 (g)(3)(A-F)	Services denied for fair and reasonable which requestor did not support. Services performed were not clarified by the requestor nor was relevant information submitted to support delivery of service. No reimbursement recommended.

DOS	REV CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
8-19-02	320	$633.25	$0.00	M	Fair and Reasonable	Rule 133.307 (g)(3)(A-F)	Services denied for fair and reasonable which requestor did not support. Services performed were not clarified by the requestor nor was relevant information submitted to support delivery of service. No reimbursement recommended.
8-19-02	360	$5,175.00	$0.00	M	Fair and Reasonable	Rule 133.307 (g)(3)(A-F)	Services denied for fair and reasonable which requestor did not support. Services performed were not clarified by the requestor nor was relevant information submitted to support delivery of service. No reimbursement recommended.
8-19-02	361	$9,200.00	$0.00	M	Fair and Reasonable	Rule 133.307 (g)(3)(A-F)	Services denied for fair and reasonable which requestor did not support. Services performed were not clarified by the requestor nor was relevant information submitted to support delivery of service. No reimbursement recommended.
8-19-02	391	$299.00	$0.00	M	Fair and Reasonable	Rule 133.307 (g)(3)(A-F)	Services denied for fair and reasonable which requestor did not support. Services performed were not clarified by the requestor nor was relevant information submitted to support delivery of service. No reimbursement recommended.
8-19-02	460	$11.80	$0.00	M	Fair and Reasonable	Rule 133.307 (g)(3)(A-F)	Services denied for fair and reasonable which

							requestor did not support. Services performed were not clarified by the requestor nor was relevant information submitted to support delivery of service. No reimbursement recommended.

DOS	REV CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
8-19-02	480	$27.60	$0.00	M	Fair and Reasonable	Rule 133.307 (g)(3)(A-F)	Services denied for fair and reasonable which requestor did not support. Services performed were not clarified by the requestor nor was relevant information submitted to support delivery of service. No reimbursement recommended.
8-19-02	710	$2,990.00	$0.00	M	Fair and Reasonable	Rule 133.307 (g)(3)(A-F)	Services denied for fair and reasonable which requestor did not support. Services performed were not clarified by the requestor nor was relevant information submitted to support delivery of service. No reimbursement recommended.
TOTAL		$19,766.65	$0.00				The requestor is not entitled to any reimbursement.

This Findings and Decision is hereby issued this 20th day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

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 Decision is applicable for dates of service 8-19-02 through 08-21-02 in this dispute.

This Order is hereby issued this 20th day of April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

NOTICE OF INDEPENDENT REVIEW DECISION amended 4/12/04

October 7, 2003

Re: IRO Case # M5-03-3174-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 42-year-old female who injured her back in ___. Details of the injury and early treatment were not provided. The patient underwent lumbar spine surgery in 1999

with little benefit. In 2001 another procedure was performed that included fusion at L5-S1 and instrumentation including pedicle screws. Apparently the patient did reasonably well for one year, but back pain developed, and she was given a diagnosis of "symptomatic hardware." While the patient was waiting surgery for hardware removal, the patient developed pain in her back and was seen in the ER on 8/19/02. The records provided indicate that the patient's pain was such that it could not be controlled with oral pain medication, and she was admitted. On 8/20/02 removal of the hardware and reexploration of the fusion site were performed.

Requested Service(s)
Hospital charges including room/board, pharmacy, medical surgical supplies, sterile supply, laboratory, x-ray, anesthesia, ER,

Decision
I disagree with the carrier's decision to deny the requested medications hospital supplies and services.

Rationale
The operative procedure that was performed is often associated with prolonged bleeding, and symphony platelet rich infusion can be helpful. 4,000 cc IV fluid is at times necessary for the procedure performed. Use of Flexeril and Soma at the same time is somewhat unusual, but the overlap of these does occur and can be helpful. Admission the night before the procedure was indicated because the patient's pain was described as intractable and not helped by oral medication. Pain control and the workup before surgery were indicated. Use of an operating room and supplies are necessary for surgery. This opinion does not address the amount of charges.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,