

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x)HCP ( )IE ( )IC	<b>Response Timely Filed?</b> (x) Yes ( ) No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M5-04-1474-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address ZNAT Ins. Co./ Rep/ Box #: 47 C/o Stone Loughlin & Swanson P.O. Box 30111 Austin, TX 78755	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2-24-03	3-1-03	Inpatient Hospitalization	\$69,512.98	\$00.00

## PART III: REQUESTOR'S POSITION SUMMARY

Position summary of March 12, 2004 states, "... In this instance the audited charges that remained in dispute after the last bill review by the insurance carrier were \$113,597.30. The prior amounts paid by the carrier were \$15,685.00. Therefore, the carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of \$69,512.98, plus interest..."

## PART IV: RESPONDENT'S POSITION SUMMARY

Position summary of April 1, 2004 states, "... Although Vista billed more than \$40,000 in this case, Vista has not cited any evidence to support that the services provided to the claimant were unusually extensive and costly... Carrier has reimbursed Vista properly under the standard per-diem plus carve-outs reimbursement method..."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

The audit summary of April 22, 2003 lists denial codes "F – Payment based on the assigned per diem amount per the 1997 Texas Inpatient Hospital Fee Guidelines", "M – Payment reduced according to fair and reasonable", "A – Payment denied since you failed to obtain preauthorization for treatment(s) and or service(s) that require preauthorization", "G – Payment for these services is included in the per diem amount" and "V – Payment has been denied because the carrier deems the treatment(s) and or service(s) to be medically unreasonable and/or unnecessary based on a peer review judgment".

Commission Rule 133.301(a) states, "... The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title (relating to Guidelines for Medical Services, Charges, and Payments)...". Forte's authorization of January 27, 2003 authorized a two-day inpatient surgical hospitalization under "Pre-Auth # 520304. Forte's authorization of February 26, 2003 authorized one (1) day of additional inpatient length of stay. Forte's authorization of February 27, 2003 authorized one (1) additional day of inpatient stay and the authorization of February 28, 2003 authorized one (1) additional day of inpatient length of stay. Therefore, the "V" denial code is moot and will not be considered.

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved “unusually extensive services.” The operative report February 24, 2003 indicates that the patient underwent a “1. Hemilaminotomy and foraminotomy with nerve root decompression left L5-S1. 2. Hemilaminotomy and foraminotomy with nerve root decompression, right L5-S1. 3. Interbody arthrodesis, L5-S1. 4. Posterior lumbar interbody instrumentation, L5-S1, two Barantigan cages. 5. Posterolateral lumbar arthrodesis, L5-S1. 6. Posterior lumbar instrumentation, Monarch screws and rods. 7. Harvesting of right iliac crest bone graft through separate incision, morselized. Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 5 days (consisting of 5 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to \$5,590.00 (5 times \$1,118). The Respondent paid \$3,354.00 (3 days for surgical) for Rev Code 110 (Room and Board Private) and paid \$12,331.00 for Rev Code 278 (Implantables). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor submitted an invoice for implantables totaling \$10,089.00.

Total of Implantables: \$10,089.00 x 10% = \$11,097.90      Total audited charges: \$2,236.00 (\$5,590.00 - \$3,354.00 amount paid) + \$11,097.90 = \$13,333.90

The Respondent reimbursed the healthcare provider \$15,685.00.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

**PART VI: COMMISSION DECISION**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

Roy Lewis

8-1-05

Authorized Signature

Typed Name

Date of Decision

**PART VII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative’s box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division’s Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision in the Austin Representative’s box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_