

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M5-04-1620-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address North American Specialty Ins./Rep. Box #: 22 P.O. Box 819045 Dallas, TX 75381	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	Did Requestor Prevail?
From	To		
4-28-03	5-3-03	Inpatient Hospitalization	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues with the exception of Rev. codes 361 and 480, which are not medically necessary.

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. The inpatient services were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

The Respondent denied inpatient services and supply/implantables with denial code "M Reduced to Fair and Reasonable" and "F Reduction According to Medical Fee Guideline".

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."

After reviewing the documentation provided by both parties, it does appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 5 days. The operative report of 4-28-03 indicates the patient underwent "1. Bilateral laminectomy, L5-S1 with bilateral foraminotomy for decompression. 2. Bilateral laminectomy, L4-5. 3. Posterior lumbar interbody arthrodesis, L4-5. 4. Posterior lumbar interbody arthrodesis, L5-S1. 5. Posterior lumbar interbody instrumentation (two Brantigan cages), L4-5. 6. Posterior lumbar interbody instrumentation (two Brantigan cages), L5-S1. 7. Posterolateral lumbar fusion, L4-5. 8. Posterolateral lumbar fusion, L5-

S1. 9. Posterior lumbar instrumentation, L4-5. 10. Posterior lumbar instrumentation, L5-S1. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding the charges for the implantables. The requestor billed \$69,768.00 for the implantables. The carrier paid \$19,027.80 for the implantables. The key issue is what amount would represent the usual and customary charges for these implantables in determining the total audited charges. The requestor provided the Commission with documentation on the actual cost of implantables, \$17,298.00.

Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%. This amount multiplied by the average mark-up of 200% results in an audited charge for implantables equal to \$34,596.00.

The audited charges for this admission, excluding implantables, equals \$93,389.28. This amount plus the above calculated audited charges for the implantables equals \$127,985.28 the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to \$69,717.96 (\$95,988.96 - \$26,271.00 (amount paid by respondent)). The IRO determined Rev. codes 361 (\$9,200.00) and 480 (\$1,231.15) not medically necessary. The Requestor's Table of Disputed Services list \$43,770.96 as the amount in dispute. Therefore, an additional reimbursement amount equal to \$33,339.91 (\$9,200.00 + \$1,231.15 = \$10,431.05 - \$43,770.96).

Based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is entitled to a reimbursement amount for these services equal to \$33,339.91.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$650.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$33,339.91, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Allen McDonald

7-27-05

Authorized Signature

Typed Name

Date of Order

PART V: 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: _____

PART VI: 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 in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.



Specialty Independent Review Organization, Inc.

December 15, 2004

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-1620-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Osteopathic Physician with a specialty in Orthopedics. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This 40-year old male was injured on ___ when he lifted a piece of metal weighing approximately 100 pounds and felt pain in his low back, radiating down his left leg with numbness and tingling. The patient was treated conservatively, but failed to gain relief. X-rays on 04 / 27 / 2003 revealed a retrolisthesis at L5-S1 and L4-5 with a vacuum sign at L4-5. The patient had an MRI that showed a herniated nucleus pulposa at L4-5 and L5-S1. A discogram was subsequently carried out and was positive for the L4-5 and L5-S1. The patient was hospitalized from 04 / 28 / 2003 through 05 / 03 / 2003 for a bilateral Laminectomy and foraminotomy at L4-5 and L5-S1, posterior interbody fusion with Brantigan Cages and a posterior lateral fusion with iliac bone graft at L4-5, L5-S1. The surgery lasted 6 ½ hours.

Records Reviewed: Intracorp 04/16/2003, Jarolimek, MD 04/03/2003, Fogel, MD 04/28/2003, Vista Medical Center 07/03/2003.

DISPUTED SERVICES

The disputed services are ancillary services from 4/28/03 through 5/3/03 as listed on the table of disputed services.

DECISION

The following services are found to be not medically necessary: Codes 361 and 480 (only 2 EKGs instead of 4 which were listed.) All other services under review are found to be medically necessary.

BASIS FOR THE DECISION

The reviewer states services as approved are medically necessary and appear to be satisfactory except for the CPT Code 480 of four EKGs because only two EKG Reports are found in the records and CPT Code 361 which is for OR Services, Minor Surgery. The Code 360 is for Major Surgery and is appropriate; however, using both Code 361 and Code 360 is duplication of services. The disputed amounts are \$6,900.00, \$238.09, and \$167.93.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director