

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 Road Pasadena, TX 77504	MDR Tracking No.: M5-04-2365-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep. Box #: 42 C/o Harris & Harris P.O. Box 162443 Austin, TX 78716	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		
4-30-03	5-17-03	Inpatient Hospitalization	<input type="checkbox"/> Yes <input checked="" 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 did **not** prevail on the disputed medical necessity issues.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Roy Lewis

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.

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity
IRO Decision Notification Letter**

Date: 12/29/2004 (Revised: 01/11/2004)
Injured Employee:
MDR #: M5-04-2365-01
TWCC #:
MCMC Certification #: 5294

DETERMINATION: Denied

Requested Services:

Please review the item in dispute regarding Semi private Hospital Room, Pharmacy, Surgical Supplies, Lab Radiology, Operating Room Services, Anesthesia, Pulmonary Function GI, Recovery Room, EKG/ECG, Cardiology.

MCMC llc (MCMC) is an Independent Review Organization (IRO) that was selected by The Texas Workers' Compensation Commission to render a recommendation regarding the medical necessity of the above Requested Service.

Please be advised that a MCMC Physician Advisor has determined that your request for M5 Retrospective Medical Dispute Resolution on 10/13/2004, concerning the medical necessity of the above referenced requested service, hereby finds the following:

There is insufficient documentation to substantiate the medical necessity of the services/charges in dispute regarding the semi-private hospital room, pharmacy, surgical supplies, lab radiology, operating room services, anesthesia, pulmonary function GI, recovery room, EKG/ECG cardiology as billed by the facility.

This is based on:

- *TWCC Notification of IRO Assignment
- *TWCC MR-117 dated 10/13/2004
- *TWCC-60 stamped received 03/30/2004 3 pgs
- *Explanation of Benefits dated 08/05/2003 5 pgs
- *TWCC-62 stamped 08/08/2003
- *Medical Business Management Services, Inc., Preauthorization Report dated 03/15/2004
- *Letter from Vista Medical Center Hospital dated 11/02/2004, 4 pgs.
- *Discharge Summary and History/Physical Examination, Vista Medical Center Hospital dated (Discharge) 05/17/2003, 8 pgs.
- *Inpatient Medical Records, Vista Medical Center Hospital, 04/30/2003 to 05/17/2003, 354 pgs.
- *Fax cover, Harris and Harris dated 11/10/2004
- *Letter from Harris and Harris dated 11/10/2004
- *Vista Medical Center Hospital, Request for Reconsideration, 39 pgs
- *Cambridge Integrated Services Group, Inc., letters dated 04/09/2003 (3 pgs), 05/02/2003 (2 pgs), 05/15/2003 (1 pg)
- *Vista Medical Center Hospital, Request for Reconsideration, 20 pgs.

The injured individual is a 48-year-old obese (5'5", 260 pound) female who sustained a back injury at work on _____. After failure of conservative treatment and continued back pain from herniated discs at L4-L5 and L5-S1 she had a laminectomy and fusion of L4-L5, L5-S1 on 12/11/2001. She did well until she noted increasing back pain for the four to five months prior to the present admission. A myelogram/CAT scan revealed an incompletely fused graft and the injured individual had increasing back pain radiating down both legs with numbness and weakness of the lower extremities. She was admitted on 04/30/2004 with bilateral straight leg raising positive, decreased sensation over the L5-S1 dermatome bilaterally and at L4 on the left side. There was 3-4+/5 lower extremity weakness. Lumbar range of motion was decreased. She has hypertension treated with Verapamil. On 05/01/2004 she had removal of EBI with electrodes, removal of hardware, exploration of the fusion mass, bone grafting and pedicle screws at L4, L5, S1 with bilateral laminectomies and foraminotomies, anterior interbody fusion L5-S1, lateral transverse fusion L4-into S2, and posterior instrumentation.

The old hardware was replaced. The injured individual is a Jehovah's Witness and signed a Refusal of Blood/Blood Components. The preoperative Hb of 13 decreased to about 9.6. She developed a post-operative CSF leak with negative cultures. The post-operative notes describe a serosanguinous discharge from the wound. It was not until 05/13/2004 that the injured individual was taken to the OR for the necessary repair of the CSF leak with replacement of hardware. She improved and was discharged on 05/17/2004. Thus, she was discharged on the fourth post-operative day after the 05/13/2004 surgery.

Each category has facility HCPCS codes that were not furnished. The exception is the recovery room charges.

There were two recovery units for a total of \$5,980.00. Certainly the injured individual required recovery room services after both surgeries. There is a customary allowance depending on the hours in the recovery room and the geographical correction for Pasadena, Texas. The injured individual was received in the recovery room on 05/01/2004 at 16:30. However, it is difficult to determine when she returned to the floor and if all of the hours in the recovery room were medically necessary. The number of hours in the recovery room should be provided in the billing. Frequently, when cases are completed at 16:30, the patients remain in the recovery room for the evening, even if not medically necessary, and there is a large recovery room charge which is in addition to the daily rate for the same day for the hospital bed.

Other charges are even more difficult to evaluate. There is a pharmacy charge for 489 units of medication for \$13,311.00. This can not be evaluated as units of pharmacy charges because the different medications have individual J codes with customary allowances for each. The J codes are not provided.

There were operating room charges of \$17,250.00 and \$9,200.00 which immediately look extremely excessive. This is the room charge by the facility for two surgeries and is NOT for the surgery as done by the surgeons (CPT codes). Again, there is a customary allowance for an hourly rate for the OR and this is not provided. The billing should reflect OR time and rate per hour. Again there are separate HCPCS codes for supplies that are evaluated individually that are necessary to evaluate charges for 107, 30, 35 "units of supplies" for \$40,629.35, \$8,842.50, and \$65,547.00 respectively. Each of these component charges for the supplies must be coded and charged for proper evaluation and the facility is well aware of this requirement for payment. There is a 1 unit pulmonary function charge for \$2,590.00, which has no documentation. There are 23 units of general cardiology charges for \$1,258.40 that were not documented with HCPCS codes. Anesthesia facility charges, radiology and lab charges of \$17,070.00, \$830.20 and \$3,375.07 respectively were not documented.

The total facility bill was \$199,067.98. This does not include the billing for the surgeons and anesthesiologists for the two surgical procedures or the hospital visits for care; that is, this does not include the CPT coded services for the procedures and evaluation/management of the physicians. The only part of the facility billings than can be evaluated is the semi-private room charge for inpatient acute care. The bill was \$12,155.00 for 17 days (04/30/2004

to 05/17/2004). This calculates out to a charge for the room of \$715.00 per day. Not all of the days were medically necessary. There is insufficient documentation to substantiate the medical necessity for the admission day of 04/30/2004 when the surgery was on 05/01/2004. Thus the pre-operative day was not medically necessary. Note that the injured individual was discharged on the 4th operative day after the 05/13/2004 surgery. This would be expected after the 05/01/2004 surgery also, if there was no complication of the CSF leak. It should not have taken from 05/01/2004 to 05/13/2004 for an evaluation that the CSF leak would not close and another surgical procedure was necessary. That is a wait of 12 days during which the patient had charges for inpatient acute care. There was a delay in service. The typical discharge after the 05/01/2004 surgery would be on 05/05/2004. Given the complication of the CSF leak and further evaluation for two extra days that would allow for a delay in service from 05/07/2004 to 05/13/2004 or six more days. So for the room charges of \$715/day at one pre-operative day and six post-operative days there should be a room charge of 10 days, not 17 days. So the medically necessary room charge of \$12, 155.00 should be \$7,150.00. The daily rate of \$715.00/day is customary and usual.

There were charges labeled Costasis Hemostat for \$2,025.00 on 05/01/2004 and for \$4,050.00 on 05/13/2004 (both days of surgery) and this requires further documentation prior to reimbursement.

On 05/01/2004 the five hour operating room charge was \$11,500.00 for a rate of \$2,300.00 per hour and the customary allowance should be \$850.00 per hour. Thus, the customary charge should be \$4,250.00 for the five hour operating room charge on 05/01/2004 instead of \$11,500.00 as charged. The OR room charge on 05/13/2004 was for two hours (for repair of CSF leak) and the charge was \$4,600.00; this should be a customary allowance of \$1,700.00. There was a recovery room charge of \$2,990.00 for one hour on 05/01/2004 and again on 05/13/2004 and this should be reimbursed at the customary allowance of \$400.00 for each day (not \$2,990.00 for each day). There was a pre-operative time charge of \$575.00 for 30 minutes of pre-operative time for each surgical day (05/01/2004 and 05/13/2004) and this should not be reimbursed.

There were charges for various items that should not be reimbursed and are included in the daily room charges discussed previously: 4/30/2004: water pitcher (\$6.00), emesis basin (\$3.00), tooth paste (\$5.00), tooth brush (\$4.95), shampoo (\$3.50), wash basin (\$5.25), tissue (\$5.75), Hospital pillow (64.50), soap (\$3.00), lotion (\$3.95). There were multiple charges for exam gloves for \$6.00 each. Boxes of 50 of sterile gloves can be purchased for \$39.59, \$32.89. That is less than \$0.80 each. On 04/30/2004 there was a \$60.00 charge for 10 exam gloves and on 05/01/2004 there were charges for gloves of \$7.75, \$23.25, \$36.75, \$24.50, \$49.00, \$49.00, \$24.50, \$54.00, \$18.00, \$6.00, \$36.00, \$24.00, \$18.00, \$24.00, \$12.00. On 05/02/2004 there were charges for gloves of \$54.00, \$18.00. On 05/03/2004 charges for gloves were \$48.00, \$18.00, \$6.00. On 05/04/2004 charges for gloves were \$96.00. On 05/05/2004 the charges for gloves were \$54.00 and \$42.00. On 05/06/2004 the charge for gloves was \$66.00. On 05/07/2004 the charges for gloves was \$24.00 and \$30.00. In summary each of these glove charges (again the price for sterile gloves is more than non-sterile) should be reimbursed at 13% to 15% of the amount charged.

Charges for sheets are part of the room charges. This was a charge of \$60.00 for a sheet. The syringe charge was \$6.75 and the needle charge was \$1.50 each. There were multiple charges for these items and a box of various types of syringes and needles together are about \$28.00 for a box of 50. That is \$0.56 for each syringe and needle unit. Again, the mark up between the cost of the item and the charge is excessive. There were multiple charges for durable equipment that again should not be reimbursed as these items are used for multiple patients and are not disposable: Examples include on 05/01/2004 a charge of \$463.00 for a headlight and a blood/fluid warmer (\$99.00), on 05/01/2004 a wheel for a walker (\$114.25) and the same day a walker without wheels (\$265.00). This was an extensive charge for a walker that was not used on the day of surgery (5 hours in the OR and 2 hours in the recovery room). Again, purchasing suture material in bulk as in a hospital is \$21.00 to \$31.00 for a box of 12. Thus, charges for sutures of \$350.00, \$25.00 and \$45.00 on 05/01/2004 are excessive. The charge for each pack of suture material is \$25.00 to \$45.00 which is a markup of 12 to 25 times the cost. In general, charges for durable

medical equipment like oximetry, EKG monitoring, wound vac pumps (\$485.00 daily) and cannisters (\$209.75 multiple times), wound vac assembly (\$259.95 multiple times) should not be reimbursed.

For all of the other billing/charges categories there is insufficient documentation available as noted in the following: There was a charge of \$18.00 for benzoin which costs \$3.50 for a bottle of 120 ml. It is used sparingly to apply to the skin for dressings to adhere better. 500 cc of Benzoin costs \$10.50. There was a charge for the use of a back brace for \$5,125.00. A tennis ball charge was \$4.50. There was a hypothermia blanket charge on 05/01/2004 for \$122.50. This is included in the multiple charges for the same day of OR, recovery room and regular room. On 05/01/2004 there were charges of \$2,775.00 for a process disp kit and \$1,800.00 for Neptune suction and \$1,750.00 for a symphony PCS. These are excessive and should not be reimbursed. A Burr striker was \$750.00 and also should not be reimbursed. There was a daily charge for the use of a flowtron pump for \$177.00 a day for 17 days. This is not a disposable unit and should not be reimbursed. There is a daily charge for a flowtron calf for \$273.00 that should not be reimbursed. There is a daily charge for the trapeze for \$25.00 that should not be reimbursed. Again the daily charge of \$485.00 for the wound Vac and wound vac drape for \$50.75 multiple times per day should not be reimbursed. There were similar charges on 05/13/2004 for charges pertaining to the 05/01/2004 surgery that should not be reimbursed such as again headlight (\$463.00), pillow (\$21.50). Again there was a benzoin charge for \$18.00. There was an excessive charge on 05/13/2004 for 6 drape towels for a total of \$495.00 (\$82.50 each).

There are multiple charges under code A4649 for \$689.00, \$3,960.00, \$13,800.00, \$3,174.00, \$7,920.00, \$1,600.00, \$1,564.00, \$7,000.00, \$17,500.00, \$3,500.00, \$1,240.00, \$1,240.00, \$2,320.00, and \$580.00 (all on 05/13/2004). There was a similar charge for code A4649 on 05/01/2004 for \$9,200.00. These are for supplies for neurosurgery and again the mark up between cost and charge is excessive.

The charge for a PTT on 04/30/2004 was \$49.50. This is CPT 85730 which has a 50 percentile customary allowance of \$27.64 and a 75th percentile customary allowance of \$37.52. For similar listing of CPT code and charge followed by customary allowance at (50th percentile) and [75th percentile] see the following: 85025 CBC \$100.10 - (31.56), [36.80]. 80053 CMP \$153.50 - (48.58), [64.18]. 80048 BMP \$163.50 - (35.18), [46.47]. 85651 ERS \$31.62 - (20.33), [27.59]. 72052 XRY \$275.00- (152.17), [182.84] and this includes professional component interpretation of xray.

There were also excessive charges for pharmaceuticals: Flexeril \$5.30 charge should be \$1.38. Ambien \$14.15 charge should be \$2.81. Ultram \$4.70 charge should be \$1.24. Thrombin 5000 units charge was \$239.40 and should be \$10.47. Sodium Chloride NS 1 liter charge was \$77.60 and this should be \$2.12. Vancomycin 1 gram charge was \$77.60 and this should be \$15.60. Zofran 4 mg charge was \$122.85 and should be \$20.16. Famotidine 20 mg tablet charge was \$8.10 and should be \$1.74. Levaquin tab 250 mg charge was \$34.70 and should be \$9.22. Neurontin 300 mg tab charge was \$5.75 each and should be \$1.39. Xanax 1 mg charge was \$10.55 and should be \$3.02. Diprivan 20 mg charge was \$68.95 and should be \$17.26. These are examples of the many excessive charges in the invoice.

The reviewing provider is Board Certified in Internal Medicine and certifies that no known conflict of interest exists between the reviewing Internists and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5).

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of TWCC on this

11th day of January 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: _____