

MDR Tracking Number: M5-04-2908-01

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, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 05-06-04.

I. DISPUTE

Whether there should be additional reimbursement for hospital admission of 05-11-03 through 05-13-03 and 05-18-03 through 05-23-03. Carrier denied services as "TX M No Mar and TX S Supplemental Payment". The carrier reviewed per TX WC Fee schedule and RN Medical Review, Peer Review dated 10-02-03 claimant could have treated at a lesser level of care without the need for confinement for dates of service 05-11-03 through 05-22-03.

II. RATIONALE

Audit reductions are made per Rule 133.1, 133.301 and 134.401. Per Rule 134.401(c)(6)(V), "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." According to Rule 134.401 (b)(2)(A) all hospitals are required to bill usual and customary. The requestor billed usual and customary. The carrier's audit (EOBs) and response failed to prove the requestor's charges were not their usual and customary. Additionally, the attached IRO decision deemed all inpatient services to be medically necessary.

According to Rule 134.401(c)(6), the services in dispute are to be reimbursed per the Stop-Loss Method. Stop-loss is an independent methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. Rule 134.401(c)(6)(A)(i) states that to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000. The reimbursement for the entire audited admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%. The Stop-Loss Reimbursement Factor is multiplied by the total audited charges to determine the Workers Compensation Reimbursement Amount (WCRA) for the admission.

The requestor identified nine (9) dates of service in dispute according to the TWCC-60 table. The total billed for those dates was \$78,625.22.

Accordingly, Rule 134.401(c)(6)(B) states the formula for calculating the appropriate reimbursement is:

\$78,625.22	Total billed charges
<u>-0.00</u>	Proper audit reductions
78,625.22	Total audited charges
<u>x 75%</u>	SLRA
58,968.92	Total recommended reimbursement
<u>-32,021.08</u>	Payments made for the nine (9) dates of service
\$26,947.84	Additional reimbursement recommended (WCRA)

This Findings and Decision is hereby issued this 13th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Dispute Review

DLH/dlh

III. DECISION & ORDER

Based upon the IRO decision the Division has 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. The Division also determined that the requestor **is** entitled to additional reimbursement for the hospital admission of 05/11/03 through 05-13-03 and 05-18-03 through 05-23-03. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby **ORDERS** the Respondent to remit additional reimbursement in the amount of **\$26,947.84** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Order is hereby issued this 13th day of October 2004.

Hilda B. Baker, Manager
Medical Review Division

HBB/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

August 5, 2004

Requestor

Spring Branch Medical Center
c/o Hollaway & Gumbert
Attn: _____
3701 Kirby Drive, Suite 1288
Houston, TX 77098-3926

Respondent

Zurich American Insurance Company
Attn: _____
Fax #: 512-867-1733

RE: Injured Worker:
MDR Tracking #: M5-04-2908-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in orthopedic surgery, by the American Board of Orthopedic Surgery, licensed by the Texas State Board of Medical Examiners (TSBME) in 1973, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating 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 the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 50-year-old male with a history of smoking was injured at work on _____. He was lifting heavy materials while employed as a brick mason. The patient underwent a lumbar fusion on 05/16/02. On 04/21/03 the patient presented to the emergency room with complaints of bown and bladder dysfunction, severe low back pain with radiation to the lower extremities and numbness. The patient developed increased pain over the next several days and had drainage at the surgical site. He was admitted on 05/06/03 with a diagnosis of osteomyelitis and placed on IV antibiotic therapy. He underwent removal of the old hardware, debridement, exploration of a lumbar spinal fusion mass, and insertion of Tobramycin-impregnated antibiotic beads. He also had a central line placed for continued antibiotic therapy. The patient was discharged seventeen days later on 05/23/03.

Requested Service(s)

Hospital room and board charges for dates of service 05/11/03 through 05/13/03, and 05/18/03 through 05/23/03.

Decision

It has been determined that the hospital room and board for 05/11/03 through 05/13/03 and 05/18/03 through 05/23/03 was medically necessary to treat this patient.

Rationale/Basis for Decision

The patient was admitted for treatment of a wound infection of his back, which included long term antibiotic therapy. The medical records included copies of the orders which indicated the patient was on intravenous (IV) medication to include four antibiotics. The patient was also placed on a patient-controlled analgesia (PCA) pump for self-administered pain medication given through the intravenous line. This antibiotic and analgesic therapy was reasonable and necessary for the treatment of the patient based on the medical record documentation provided. Therefore, the hospital room and board for 05/11/03 through 05/13/03 and 05/18/03 through 05/23/03 was medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

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.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 5th day of August 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: