

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> ( ) Yes (x) No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M5-05-0601-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Pacific Employers Ins. Co./Rep. Box #: 15 C/o ACE USA/ESIS P.O. Box 5574 Houston, TX 77508	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		
10-24-03	10-28-03	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.

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 the surgical admission date and surgical admission with "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 4 days. The operative report of 10-24-03 indicates the patient underwent a "Revision total knee with Scorprio size 11 tray with 8 mm 30 degree offset with 11 mm x 155 stem and 15 mm polyethylene."

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 \$29,056.00 for the implantables. The carrier did not allow any

reimbursement 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, \$6,373.00.

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 \$12,746.00.

The audited charges for this admission, excluding implantables, equals \$77,310.17. This amount plus the above calculated audited charges for the implantables equals \$90,056.17, the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to \$65,306.13 (\$66,424.13 (amount in dispute as listed on the Table of Disputed Services) -\$1,118.00 (amount paid by respondent)).

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 \$65,306.13.

#### **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 \$65,306.13, 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

7-19-05

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.**

## NOTICE OF INDEPENDENT REVIEW DECISION

January 20, 2005

Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking #: M5-05-0601-01  
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 §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1978. 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 53 year-old male injured his left knee on \_\_\_ while at his place of employment. He underwent a revision total knee with Scorpio size 11 tray with 8 mm 30 degree offset with 11 mm x 155 stem and 15 mm polyethylene on 10/24/03. He remained in the hospital until 10/28/03.

### Requested Service(s)

Ancillary Services: Semi private room, pharmacy, drugs/generic, medical-surgical supplies, sterile supplies, laboratory, X-ray, X-ray other, operating room services, anesthesia, pulmonary functions, cardiology, and recovery room for dates of service 10/24/03 through 10/28/03

### Decision

It is determined that there is medical necessity for the ancillary services: semi private room, pharmacy, drugs/generic, medical-surgical supplies, sterile supplies, laboratory, X-ray, X-ray other, operating room services, anesthesia, pulmonary functions, cardiology, and recovery room for dates of service 10/24/03 through 10/28/03 to treat this patient's medical condition.

### Rationale/Basis for Decision

The surgery performed was a total knee revision. A primary total knee has a usual length of stay of four days using all the ancillary services listed. A revision total joint is always more extensive and requires a longer length of stay with a higher medical necessity of ancillary services. Therefore, the ancillary services: semi private room, pharmacy, drugs/generic, medical-surgical supplies, sterile supplies, laboratory, X-ray, X-ray

other, operating room services, anesthesia, pulmonary functions, cardiology, and recovery room for dates of service 10/24/03 through 10/28/03 was medically necessary to treat this patient's medical condition.

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm

Attachment

**Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #: M5-05-0601-01**

**Information Submitted by Requestor:**

- Procedures
- Claims
- Historical Information

**Information Submitted by Respondent:**