

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? () Yes (x) No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M5-05-1838-01
	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 759 Houston, TX 77001	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		
4-30-04	5-2-04	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, rendered on 2-18-03 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 Rev. Codes 120, 250, 272, 300, 320, 329, 341, 420, 460, 480 and 710 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 **not** appear that these particular admissions involved "unusually extensive services." The operative report of April 30, 2004 indicates the patient underwent a lumbar laminectomy, discectomy and foraminotomy and partial facetectomy right and left at L3-4, L4-5 and L5-S1. 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 the admission is 2 days (consisting of 2 days for surgical). Accordingly, the standard per diem amount due for the admission is equal to \$2,236.00(2 days times \$1,118.00). The Respondent reimbursed \$2,236.00. In

addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit any information; therefore, MDR cannot determine the cost plus 10%.

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

7-26-05

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.



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 16, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-1838-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 an Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Operative report dated 4/30/04 from Vista Medical Center Hospital
- Final accounting from Vista Medical Center Hospital dated 7/11/04
- Appeal letter dated 3/11/04 from Vista Medical Center Hospital

Submitted by Respondent:

- Operative report dated 4/30/04 from Vista Medical Center Hospital
- Surgical pathology report from Vista Medical Center Hospital dated 4/30/04
- Anesthesia evaluation dated 4/30/04 from Vista Medical Center Hospital
- Letter of response for request for medical dispute resolution dated 4/14/05 from Vista Medical Center Hospital

Clinical History

The claimant has a history of chronic back pain allegedly related to a compensable injury on _____. The claimant underwent a lumbar laminectomy/discectomy, foraminotomy and partial fasciectomy at L3/4, L4/5, and L5/S1 bilaterally on 4/30/04.

Requested Service(s)

270 medical-surgical supplies and 370 anesthesia for dates of service 4/30/04 through 5/2/04

Decision

I disagree with the carrier and find the medical/surgical supplies and anesthesia supplies medically necessary.

Rationale/Basis for Decision

Best this reviewer can determine, the operation which the claimant underwent was pre-authorized. Since the operation was pre-authorized, associated medical-surgical and anesthesia supplies have to be considered to be medically necessary. It is, therefore, difficult for this reviewer to fully understand the reason for this review. If the issue is the amount of charges for the individual items billed, a physician reviewer is not trained to evaluate acquisition cost vs. charge, with respect to usual, customary, and reasonable. Neither is it possible for a physician reviewer to look at a list of medical-surgical or anesthesia services and identify whether there have been supplies or services billed which did not take place.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 16th day of May 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder