

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x)HCP ()IE ()IC	Response Timely Filed? () Yes (x) No
Requestor's Name and Address Vista Hospital of Dallas 4301 Vista Road Pasadena, Texas 77504	MDR Tracking No.: M5-05-2436-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Manufacturers Mutual Insurance Company P O Box 162443 Westlake Station Austin, Texas 78716 Box 42	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	Amount in Dispute	Amount Due
From	To			
05/28/04	06/05/04	Surgical Admission	\$162,842.74	\$162,842.74

PART III: REQUESTOR'S POSITION SUMMARY

“According to the literal interpretation of TWCC Rule 134.401 and the further clarification by the TWCC from QRL 01-03, a Carrier may not ‘deduct’ any carve-out costs listed in Rule 134.401(c)(4). Further, additional reimbursement for implants or any other ‘carve-out costs’ shall only be reimbursed at cost plus 10% if the stop-loss threshold is NOT met. Therefore, in this instance, the Carrier has severely under-reimbursed the billed charges, despite the clear language in the Texas Administrative Codes and further clarification by the TWCC in QRL 01-03.”

PART IV: RESPONDENT'S POSITION SUMMARY

No response noted in the case file.

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

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 additional 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 the provider, operative documents revealed two major surgical interventions (posterior lumbar interbody fusion and anterior lumbar interbody fusion), it **does** appear that this particular admission involved “unusually extensive services”. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss threshold.

Per Rule 133.301 the carrier did not perform a line item audit indicating a recommended allowance. The carrier reimbursed the provider a total of \$8,944.00, leaving \$162,842.74 in dispute.

Using the stop-loss methodology the total allowable WCRA is \$229,048.99.

The carrier has reimbursed the provider \$8,844.00.

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 an additional reimbursement for these services equal to \$162,842.74 (total allowable WCRA \$229,048.99 x 75% = \$171,786.74 - \$8,944.00 already paid = additional reimbursement of \$162,842.74).

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$162,842.74. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20 days of this Order.

Ordered by:

08/02/05

Authorized Signature

Typed Name

Date of Order

PART VII: 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.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____



Barton Oaks Plaza Two, Suite 200
901 Meopax Expressway South • Austin, TX 78746-5799
Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

July 28, 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: ___r
MDR Tracking #: M5-05-2436-01
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 1983. 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 52 year-old female was injured on ___ in a work related event. She complained back pain radiating to her hip and leg and had failed conservative treatment repeatedly. She underwent an anterior/posterior L3 to the sacrum fusion with instrumentation and right sided decompression L4-5 and L5-S1 on 05/28/04.

Requested Service(s)

Nuclear medicine/diagnosis on dates of service 05/28/04 through 06/05/04

Decision

It is determined that there is no medical necessity for the nuclear medicine/ diagnosis on dates of service 05/28/04 through 06/05/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation does not substantiate a diagnosis supporting the need for nuclear medicine nor does it indicate that nuclear medicine testing was performed or ordered for this patient. Therefore, the nuclear medicine/diagnosis on dates of service 05/28/04 through 06/05/04 are not medically necessary to treat this patient's medical condition.

Sincerely,



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

GBS:dm
Attachment

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: _____
TWCC ID #: M5-05-2436-01

Information Submitted by Requestor:

- Discharge Summary
- Progress Notes
- Operative Report
- Lab and Diagnostic Tests
- Order
- Medication Administration Record
- Nursing Notes

Information Submitted by Respondent:

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