MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

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 77503	MDR Tracking No.: M5-03-1327-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Pacific Employers Insurance Company Box 15	Date of Injury: Employer's Name: Securitas Security Services Insurance Carrier's No.: C290C0967659

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/06/2002	02/14/2002	Pre-admission Outpatient Services and Inpatient Hospitalization	$68,558.79	$3,344.50

PART III: REQUESTOR'S POSITION SUMMARY

The insurance carrier did not use the correct payment exception code on the Explanation of Benefits (EOB). Since the EOB is inadequate, there should be no denial of reimbursement and the insurance carrier should be found liable for the treatment. The carrier denied most of the services with a "V" code, referencing "Unnecessary treatment – with peer review." The carrier had preauthorized the surgery in question and so the carrier should not be allowed to retrospectively deny this treatment based on medical necessity. The carrier previously paid $1,127.50 and should be required to reimburse the remainder of the amount due, which equals $68,558.79, plus interest.

PART IV: RESPONDENT'S POSITION SUMMARY

A review of system notes appear to show that a response was timely received, but it was not located in this particular dispute file. It is noted that the EOB showed that services were denied as unnecessary medical treatment based on a peer review.

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

This is an older dispute with many different complicating factors impacting the final outcome of the decision. The first issue related to the "preauthorization" question. On January 16, 2002, the Commission sent the parties a letter that the carrier had failed to respond to a spinal surgery request under the provision of Rule 133.206 and indicated that the carrier was liable for the requested spinal surgery. In other words, the carrier did not really "preauthorize" the spinal surgery, but became liable for the requested spinal surgery due to an administrative processing omission and/or error. A review of the notes in our system show that the carrier attempted to dispute this finding by requesting a Benefit Review Conference on or about February 28, 2002, but was told that the issue would be under the purview of Medical Dispute Resolution.

While Rule 133.206(b)(1) does contain provisions that would make a carrier liable for spinal surgery if a second opinion is not timely requested, there are other provisions in this same rule that must be considered. Rule 133.206(b)(3) states that if a carrier becomes liable, "disputes regarding the proposed and concurred upon type of spinal surgery shall be limited to a dispute as to the reasonableness of the fees charged." This subparagraph further states, "(a) carrier may challenge whether medical care related to the spinal surgery is medically necessary." Accordingly, the question on the "requested" spinal surgery and the "medical necessity" of the extensiveness of the surgical interventions must be addressed.

It appears that the request for spinal surgery was to perform the following surgical procedures:

63047 – Laminectomy, facetectomy and foraminotomy, single vertebral segment, lumbar;

22630 – Arthrodesis, posterior interbody technique, single interspace, lumbar; and
22852 – Removal of posterior segmental instrumentation.

Generally, the spinal surgery second opinion process was structured to secure agreement or disagreement that the proposed type of spinal surgery is needed, not necessarily the levels of the surgery. In these types of situations, where the doctor performed a much more extensive operation than originally requested, the question regarding the extensiveness of the procedure (or the number of levels involved in the actual surgical procedures) becomes an issue of medical necessity. The doctor should have submitted the documentation to the carrier to explain why multiple levels were medically necessary, and the carrier has the ability to dispute the extensiveness of the surgery or the number of levels on those grounds. Given the prior finding of carrier liability, it appears that the medical necessity issue is related to the extensiveness of the procedures.

This dispute was sent to an Independent Review Organization (IRO) to secure an appropriate opinion on the medical necessity issue. The IRO's report included the following findings: "It is apparent from a review done by Dr. Mark Rogers in December of 2001, that the multilevel fusion performed in April 2001 was not medically necessary for an isolated, right S1 radiculopathy where reasonable and necessary surgery would be a laminectomy and discectomy at the L5-S1 level." The IRO further stated that the surgical care from 2/7/02 to 2/14/02 was "not medically necessary." Based on these findings, it appears that the procedures done were found not to be medically necessary. Accordingly, the requestor did **not** prevail on the issue of medical necessity and is **not** owed a refund of the paid IRO fee.

Regarding the amount of reimbursement to be adjudicated, this part of the 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."

In working this case and reviewing the documentation, I was presented with several options:

- Follow the IRO report, as written, and order no reimbursement for any of the days based on the lack of medical necessity (which would appear to contradict the previous finding of carrier liability for the requested spinal surgery);
- Order reimbursement for the full admission using the stop-loss methodology (which would appear to contradict the finding of the IRO that the services were not medical necessity); or
- Determine some other approach that would generally be acceptable as medically necessary for the requested surgery but considers the differences between the requested surgical procedures and the actual surgical procedures (balancing the finding of carrier liability and the IRO decision on medical necessity).

Based on the findings of the IRO, it does not appear that the provider submitted sufficient documentation to support that the extensiveness of the actual surgery was medical necessary and the carrier cannot be found liable for all the services associated with the admission. However, the previous finding of the Commission that the carrier was liable for the "requested" spinal surgery cannot simply be discounted or ignored. Accordingly, I find that the carrier is liable for the single level lumbar spinal surgery, as requested by the doctor in the spinal surgery second opinion process.

Since the carrier was liable for a single level lumbar procedure (and not the extensive surgical intervention actually performed by the doctor and later disputed by the carrier as not medically necessary), I find that this admission does **not** appear to involve "unusually extensive services." 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 this admission was seven days. However, it is difficult to discern what portion of the seven-day admission was related to the "requested" single-level procedure compared to the multi-level procedure actually performed by this doctor, which again raised the same questions regarding the appropriate approach. It was noted that the Official Disability Guidelines published by the Work Loss Data Institute shows that the average length of a hospital stay related to these procedures is between 3.8 days (laminectomy) and 4.6 days (fusion). Accordingly, I find that the carrier's liability is for a four-day surgical admission. The standard per diem amount due for this admission is equal to $4,472.00 (4 times $1,118).

In addition, the hospital is entitled to additional reimbursement for implantables; but the requestor submitted no invoices or supporting documentation to support a cost plus ten percent order on implantables.

The last issue to be resolved in determining the final amount to be ordered relates to the outpatient services performed on February 6, 2002. On July 24, 2003, the Medical Review Division submitted a notice to the requestor to submit additional information necessary to support the charges and to challenge the reasons the respondent had denied reimbursement. The requestor did not provide any reasonable information to explain their charges or to show that any amount due would be considered a "fair and reasonable" reimbursement. The services provided could have possibly been performed during the admission and there is no documentation to show any valid rationale supporting separate reimbursement for this particular day of services. Accordingly, reimbursement is not recommended.

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 $4,472.00. Since the carrier had previously paid $1,127.50, it appears that the health care is entitled to an additional $3,344.50 plus interest.

PART VI: 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 additional reimbursement in the amount of $ **3,344.50** . 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 receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Allen C. McDonald, Jr.	May 9, 2005

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 05/09/2005. 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, Mail Stop 35, 7551 Metro Center Dr., Suite 100, 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: _____

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 17, 2003

RE: MDR Tracking #: M5-03-1327-01
IRO Certificate #: 5242

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

____ 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. The Orthopedic Surgeon 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.

Clinical History

The claimant allegedly sustained a work-compensable injury to the lower back on ___. electromyogram nerve conduction studies showed evidence suggesting a right S1 radiculopathy. MRI showed a herniated disc at L5-S1. She was referred to ___, eventually, for surgery. In April 2001, she apparently needed to undergo laminectomy and discectomy at L5-S1. However, she underwent multilevel laminectomy, foraminotomies, anterior and posterior spinal fusions, and insertion of an epidural catheter. Battery was placed to help with incorporation of spinal fusion. It is apparent from a review done by ___ in December of 2001, that the multilevel fusion performed in April 2001 was not medically necessary for an isolated, right S1 radiculopathy where reasonable and necessary surgery would be a laminectomy and discectomy at the L5-S1 level. Not withstanding the deviation of standard of care related to the initial surgery of April of 2001, according to a history of present illness performed by ___ February 6, 2002, claimant had been well until the last several months prior to the date of admission of 2/6/02 when she had increasing pain. The only study documented in the present illness is a myelogram, which apparently showed some evidence of pseudoarthrosis and possible hardware loosening. Patient was admitted to an ambulatory surgery center on 2/7/02 and underwent an extensive spinal reconstruction procedure of the lumbar spine and was discharged on 2/14/02.

Requested Service(s)

Was the ambulatory surgical care on 2/7/02 to 2/14/02 medically necessary?

Decision

I agree with the insurance carrier that the ambulatory surgical center care on 2/7/02 to 2/14/02 was not medically necessary.

Rationale/Basis for Decision

There is no objective documentation of radiculopathy by electromyogram nerve conduction study. There is no documentation of specific pain generator site by discography. There is no documentation by CT scan of pseudoarthrosis. Myelogram is not the procedure of choice for diagnosis of pseudoarthrosis or hardware loosening. There is no clear clinical

correlation between clinical diagnosis of pseudoarthrosis and claimant's chronic pain condition. There is no documentation of exhaustion of conservative treatment measures in this patient with failed back syndrome.