

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (x) Yes ( ) No
Requestor's Name and Address Spring Branch Medical Center C/O Hollaway & Gumbert 3701 Kirby Drive, Suite 1288 Houston, Texas 77098-3926	MDR Tracking No.: M4-05-0797-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address National American Insurance Company 901 S MoPac Expressway, Building 4 Austin, Texas 78746-5776 Box 02	Date of Injury:
	Employer's Name: Rail UN LTD, Inc.
	Insurance Carrier's No.: X1992015

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/26/03	10/04/03	Surgical Admission	\$25,020.45	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

"It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines of the Texas Workers' Compensation Commission (TWCC)."

## PART IV: RESPONDENT'S POSITION SUMMARY

"Respondent requests the TWCC Medical Review Division to find that the amount reimbursed in this case is appropriate per the TWCC Medical Fee Guidelines."

## 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 information provided by both parties, it does **not** appear that this particular admission involved "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 operative report indicates that a posterolateral arthodesis at C4-5, 5-6 and 6-7 was performed. The operative report also indicates that no problems were noted and was transferred to the recovery room in satisfactory condition.

The carrier made reimbursement based on per diem and carve out of the implantables (8 day stay) bringing the total amount of reimbursement to \$32,587.29. The requestor did not submit an invoice to determine reimbursement for the implantables; therefore MDR cannot determine the cost of the implants.

Therefore, 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 not entitled to an additional reimbursement.

**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.

Ordered by:

Michael Bucklin

06/07/05

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, 7551 Metro Center Drive, 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: \_\_\_\_\_