MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (X) No
Requestor Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M4-05-1099-01 TWCC No.: Injured Employee's Name:
Respondent's Texas Mutual Insurance Co. Rep. Box # 54	Date of Injury: Employer's Name: American Habilitation Services Insurance Carrier's No.: 99-228743

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
12-15-03	12-24-03	Inpatient Hospitalization	$67,856.97	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

M – Code used improperly to designate reimbursement per Acute In-Patient Stop Loss Fee Guideline.
F – Payment not in accordance with Acute In-Patient Fee Guideline.

PART IV: RESPONDENT'S POSITION SUMMARY

This carrier reimbursed the requester surgical per diem ($1,118) based on the TWCC Acute Care In-Patient Fee Guideline for nine days of the stay. This carrier also reimbursed the requester cost plus 10% for implantables…The carrier maintains the right to audit hospital charges as provided for by TWCC Rule 133.301, 134.401, 134.600, 133.206. Section 413.011(b) of the Texas Labor Code mandates that the "Guideline for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control…" It is this carrier's position that a percent of an artificially inflated UNLIMITED billed amount is not effective medical cost control.

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 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."

Operative report indicates claimant underwent right left lumbar hemilaminectomy, foraminotomy and nerve root decompression at L5-S1; Posterior lumbar interbody instrumentation (2 Ray cages) at L5-S1; Posterior and posterolateral lumbar interbody arthrodesis at L5-S1.

Carrier submitted a peer review that indicated that, "Postoperatively the patient developed fever, was placed on a wound vac and oral Levaquin. There are comments in the medical records per the physician's assistant that the patient was kept in-house three days while pre-authoirzation was obtained for home antibiotics, nursing services and wound vac."

After reviewing the documentation 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 total length of stay for this admission was 9 days (consisting of 9 days for surgical). Accordingly, the standard per diem amount due

for this admission is equal to $10,062.00 (9 times $1,118.00). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

Invoice $5,394.00 + 10% = $5,933.40.

The insurance carrier paid $5,933.40 + nine days surgical per diem for the inpatient hospitalization.

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 additional reimbursement is not 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:

	Elizabeth Pickle	April 25, 2005
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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____