# 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<br>Memorial Hermann Hospital System<br>C/o Sullins & Johnston<br>3200 S.W. Freeway, Ste. 2200<br>Houston, TX 77027 | MDR Tracking No.: M4-05-1306-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br>Insurance Co. of the State of PA/Rep. Box #: 19<br>C/o Flahive, Ogden & Latson<br>P.O. Box 13367<br>Austin, TX 78711-3367 | Date of Injury:<br>Employer's Name: Cargill Inc.<br>Insurance Carrier's No.: 006430000879110001 |

## PART II: SUMMARY OF DISPUTE AND FINDINGS

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 10-19-03 | 11-10-03 | Inpatient Hospitalization | $22,234.42 | $22,234.42 |
| | | | | |

## PART III: REQUESTOR'S POSITION SUMMARY

Position summary of October 15, 2004 states, "…Due to the nature of the patient's post operative bacterial wound infections and cerebrospinal fluid leak from his back surgery, the patient required unusually extensive services and supplies during his stay. The patient was hospitalized for a period of 22 days. The hospital billed its usual and customary charges in the total amount of $81,991.88. Due to the unusually extensive services and supplies provided and the patient's extended length of stay, the hospital's usual and customary charges for room and board, ancillary services and drug charges exceeded the stop loss threshold found in the Acute Care Inpatient Hospital Fee Guideline, Rule 134.401 (c)(6). Accordingly, the carrier should have applied the Stop Loss Reimbursement Factor (SLRF) and paid the 75% of the hospital's usual and customary charges…".

## PART IV: RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response.

## 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."

After reviewing the documentation provided by both parties, it does appear that this particular admission involved "unusually extensive services." The submitted UB-92 identifies the "Prin. Diag. Code" as "998.59" Other postoperative infection and "Prin. Procedure" as 03.59 as Other repair and plastic operations on spinal cord structures. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

The Hospital Bill Audit Report of December 16, 2003 lists the "U" denial code for Y3200 and Y7610 on October 19, 2003 along with denial codes "F" and "N". The Requestor discusses these denial codes in the position summary of October 15, 2004. The Requestor states, "…the carrier did not identify which service or supply it considered … "unnecessary". Generic statements that simply state a conclusion such as "not sufficiently documented" or similar phrases with no further description for the reduction or denial of payment does not satisfy Commission Rule 133.304 (c). Accordingly, the hospital could not determine with any degree of certainty why its total charges were substantially reduced.". The Respondent did not submit a position summary that discusses the "U" denial code. Therefore, the "U" denial code is moot and will not be addressed.

The Requestor billed $81,991.88. The Respondent reimbursed $39,259.15. Due to the medical information provided, the admission

involved "unusually extensive services". Therefore, the stop-loss reimbursement factor of (75%) results in a workers' compensation reimbursement amount equal to $22,234.42 ($61,493.91 - $39,259.15).

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 $22,234.42.

**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 $22,234.42. 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:**

| | Allen McDonald | 5-17-05 |
|---|---|---|
| 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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____