

# 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 HCA Healthcare 6000 NW Parkway, Suite 124 San Antonio, Texas 78249	MDR Tracking No.: M4-05-1466-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Pacific Employers Insurance Company C/O Law Offices of John D. Pringle 9901 Brodie Lane, Suite 160 PMB 225 Austin, Texas 78748-5612 Box 15	Date of Injury:
	Employer's Name: Anheuser Busch Companies, Inc.
	Insurance Carrier's No.: C290C091915X

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/04/04	02/07/04	Surgical Admission	\$21,595.81	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position statement.

## PART IV: RESPONDENT'S POSITION SUMMARY

"Requestor has failed to establish that the billed for services were 'unusually extensive' because of atypical patient characteristics or procedures for that same DRG and that required services were 'unusually costly' because the general reimbursement rule of per diem plus carve-outs does not adequately compensate Requestor for the costs associated with that admission. Requestor must also show that the medical services proposed are reasonable and necessary for proper treatment of the injuries sustained."

## 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 the provider, 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 this was a Posterior lumbar interbody fusion. The operative report also indicates there were no complications and patient was transferred to recovery in satisfactory condition.

The carrier made reimbursement based on per diem for the 3-day stay \$3,354 and for the cost of the implantables (invoices indicate charges in the amount of \$7,604.12) carrier reimbursed cost plus ten percent for the implantables (\$9,254.43) for a reimbursement total of \$12,608.43. The carrier correctly reimbursed the provider.

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 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

05/10/05

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: \_\_\_\_\_