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 Rd. Pasadena, TX 77504	MDR Tracking No.: M4-05-1638-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Ins. Co./Rep. Box #: 54 P.O. Box 12029 Austin, TX 78711-2029	Date of Injury: Employer's Name: Palletized Trucking Inc. Insurance Carrier's No.: 99D0000346425

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2-19-04	2-21-04	Inpatient Hospitalization	$29,331.36	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's position statement listed on the Table of Disputed Services states, "F-Payment is not in accordance with Acute In Patient fee guideline.

PART IV: RESPONDENT'S POSITION SUMMARY

Position summary of November 17, 2004 states, "… This carrier denied the charge in dispute, a hospital stay, with exception code "A". The requester did not seek preauthorization for the second day in the hospital. The requester obtained preauthorization for one day in patient hospital stay…"

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."

The Requestor is seeking review for dates of service February 19, 2004 to February 21, 2004 according to the Table of Dispute Services. The Respondent authorization of February 3, 2004 provided authorization for "Inpatient right L5 laminectomy, right S1 laminectomy and discectomy by Dr. David E. Tomaszek at Vista Medical Center with one (1) day inpatient length of stay to be completed by 03/03/04…"

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." According to the operative report of February 19, 2004 the patient underwent "Right L5 laminectomy and S1 laminectomy. 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 Respondent approved authorization for “one (1) day inpatient length of stay”. Therefore, the total length of stay for this admission was 1 day (consisting of 1 day for surgical). Accordingly, the standard per diem amount due for this admission is equal to $1,118.00 (1 times $1,118.00). The Respondent paid $1,118.00 for Rev. Code 120 (Semi Private Room). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit any invoices.

Therefore, 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 no additional reimbursement is 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:

	Roy Lewis	6-7-05
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: ________________________