Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION AMENDED FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M4-05-2053-01 **(Previously M4-03-1843-01)** Claim No.: Injured Employee's Name:
Respondent's Name and Address: Argonaut Southwest Insurance Co. Rep Box # 53	Date of Injury: Employer's Name: Angel Brothers Enterprises LTD Insurance Carrier's No.: 41001456

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier did not provide payment per the Acute Care Inpatient Guidelines.

Principle Documentation:

1. Requestor's position statement
2. EOB
3. UB-92
4. Itemized statement

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No further payment is recommended.

Principle Documentation: 1. Respondent's position statement
2. Corvel report

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12-20-01 through 12-31-01	M	Inpatient Hospitalization	1	$8,624.52
TOTAL DUE				$8,624.52

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

1 This AMENDED FINDINGS AND DECISION supersedes M4-03-1843-01 rendered in this Medical Payment Dispute involving the above requestor and respondent.

The Medical Review Division's Decision of 10-8-04 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 11-1-04. The original decision erroneously stated "that the insurance carrier failed to prove that requestors' charges were not their usual and customary." The requestor has the burden of proof to support charges are usual and customary, not the carrier.

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." In particular, this admission resulted in a hospital stay of 3 days based upon (extensive operation). 12-20-01 the claimant was treated as an outpatient. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

The requestor billed $144,687.82 for the hospitalization. In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding $41,267.24 of the charges as not being usual and customary. The requestor did not support these charges as usual and customary; therefore, no payment is recommended for these = $144,687.82 minus $41,267.24 = $103,420.58.

$182.56 of the charges were denied payment based upon "unrelated charges". These charges were patient convenience charges and payment is not recommended. $103,420.58 minus $182.56 = $103,238.02.

The requestor billed $68,940.00 for the implantables. In determining the appropriate reimbursement for implantables, it must be noted that the health care provider did not submit invoices to support charges. While this makes the determination more difficult, it would appear that implantables were clearly used during the surgical intervention and some amount is due to the health care provider. In this case, the requestor billed $68,940.00 for the implantables.

Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%. We will apply this average mark-up to the charged amount in order to determine the amount to use in the decision. Based on a charge of $68,940.00, it appears that the cost for these implantables was approximately $34,470.00 (charged amount divided by 200%). Since the reimbursement for implantables is cost plus 10%, the amount due for the implantables would equal $37,917.00.

The audited charges for this admission, excluding implantables, equals $34,298.02 ($103,238.02 minus $68,940.00). This amount plus the above calculated audited charges for the implantables equals $72,215.02, the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to $54,161.27.

The insurance carrier audited the bill and paid $45,536.75 for the inpatient hospitalization. The difference between amount paid and amount due = $8,624.52.

Reference to outpatient services rendered on 12-20-01. If a fee guideline does not exist, charges are subject to fair and reasonable. Per Section 413.011(b) states, "Guidelines 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. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines." The requestor failed to support charges were fair and reasonable and complied with Section 413.011; therefore, payment for outpatient services rendered on 12-20-01 is not recommended.

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 $8,624.52.

Therefore it is the conclusion of the Medical Review Division that additional reimbursement in the amount of $8,624.52.is due the requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
Rule 134.401
Section 413.011

PART VII: DIVISION AMENDED DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor **is** entitled to additional reimbursement of $8,624.52.

Findings and Order by:

Authorized Signature	Elizabeth Pickle, RHIA	11/30/05
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.