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 Road Pasadena, Texas 77504	MDR Tracking No.: M4-05-2166-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TPCIGA for Reliance National Indemnity 9120 Burnet Road Austin, Texas 78758-5204 Box 50	Date of Injury: Employer's Name: Smith Mobley, Inc. Insurance Carrier's No.: EL181903506

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
12/31/03	**01/06/03**	**Hospital Admission**	**$28,271.94**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

"Per Rule 134.401 (c)(6)(A)(v), the only charges that may be deducted from the total bill are those for personal items (i.e., television telephone) and those not related to the compensable injury. Moreover, Rule 134.401 (c)(6)(A)(v) states what the carrier can deduct in the audit. The carrier should not confuse the carve-out items identified in section (c)(4) as items that can be deducted in an audit or paid separately."

PART IV: RESPONDENT'S POSITION SUMMARY

"Charges for the facility in which the provider elected to have procedures or surgery performed on an outpatient basis are paid at a fair and reasonable amount pursuant to the criteria set forth in Section 413.011(b) of the Texas Workers' Compensation Act and Rule 133.1. The Texas Workers' Compensation Commission has determined that an inpatient admission is to reimbursed at $1,118.00 per day. In light of the reduced expenses incurred in an outpatient setting, it is unreasonable to pay more for an outpatient pain management procedure than for a one-day surgical admission and it is unreasonable to pay more for an outpatient surgery than for a two-day surgical admission."

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 methodology described in the same rule. The operative report indicates that this was a post dural headache. The operative report also indicates the patient tolerated the procedure well and the headache was resolved.

The carrier made reimbursement based on per diem for the 6-day stay $6,708.00(6 x $1,118 = $6,708.00 per diem). 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	04/28/05
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 and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____