# 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>Southwest General Hospital<br>7400 Barlite Blvd.<br>San Antonio, Texas 78224 | MDR Tracking No.: M4-05-2624-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br>Christus Health<br>C/O Cunningham & Lindsey Claims<br>ATTN: Ms Fatina Johns<br>Dallas, Texas 75370<br>Box 11 | Date of Injury:<br>Employer's Name: Christus Health<br>Insurance Carrier's No.: 22800005999 |

## PART II: SUMMARY OF DISPUTE AND FINDINGS

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 06/10/04 | 06/14/04 | Surgical Admission | $31,631.30 | $0.00 |
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## PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position statement.

## PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not submit a position statement.

## 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 both parties, it does **not** appear that this particular admission involved "unusually extensive services." The requestor did not submit an operative report indicating if the services were unusually extensive. 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.

Carrier denied reimbursement for the implants as "Will be considered upon receipt of itemization along with implant invoices."

The provider did not submit any invoices indicating the amount billed for the implantables. Therefore, MDR cannot determine the charges of the implantables and no reimbursement is recommended for the implantables.

The carrier made per diem reimbursement for the 4-day stay in the amount of $4,024.80 per a contract and the requestor did not refute this denial.

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 reimbursement.

**Ordered by:**

| | Michael Bucklin | 08/02/05 |
|---|---|---|
| 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: _____