

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 Hospital of Dallas 4301 Vista Road Houston, TX 77504		MDR Tracking No.: M4-05-2675-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address Employers Insurance Co. Box 28 c/o Liberty Mutual Insurance Co. 2875 Browns Bridge Rd. Gainesville, GA 60504		Date of Injury:	
		Employer's Name: Capitol USA Group	
		Insurance Carrier's No.: 197611237	

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05/24/04	05/28/04	Inpatient Hospitalization	\$16,000.48	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

TWCC Rule 134.401 provides the rules regarding reimbursement for Acute Care In-patient Hospital Fee services. Specifically, reimbursement consists of 75% of remaining charges for the entire admission, after a Carrier audits a bill... This figure is presumptively considered to be "fair and reasonable" in accordance with the preamble of TWCC Rule 134... Further, the TWCC stated that the stop-loss threshold increased hospital reimbursement and will ensure fair and reasonable rates for hospitals and ensure access to quality health care for injured workers...

PART IV: RESPONDENT'S POSITION SUMMARY

We have received the medical dispute filed by Vista Hospital of Dallas for services rendered to [injured worker] between dates of service 5/24/04-5/28/04. The bill and documentation attached to the medical dispute has been re-reviewed and our position remains the same...

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."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." According to the Discharge Summary claimant underwent an anterior cervical disk fusion at C6-7 with instrumentation. On the third postoperative day the claimant began to complain of right arm numbness, a CT scan was performed and the results were unremarkable. Later in the day the claimant complained of right leg swelling; a baker's cyst was discovered. The fourth postoperative day the claimants' incision sites looked excellent with no evidence of infection, no swelling and only minimal serosanguineous drainage from the site where the JP drain had been. The tenderness in his right leg was resolving. Throughout his hospital stay, the patient never developed a fever. 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 total length of stay for this admission was 4 days (consisting of 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to \$4,472.00 (4 times \$1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The healthcare provider submitted an invoice Commercial Capital Management A/C Spinal Solutions, LLC in the amount of \$6,450.00; this amount times 10% equals \$7,095.00. The healthcare provider also performed a CT scan during the hospital stay in the amount of \$1,424.50. The total reimbursable amount should have been \$12,991.50.

The insurance carrier reimbursed the healthcare provider \$46,121.68. 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:

Marguerite Foster

May 19, 2005

Authorized Signature

Typed Name

Date of Decision

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 en 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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____