# 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<br>Advanced Practice, Inc. on behalf of Baylor All Saints Medical Center<br>17101 Preston Road, Suite 180-S<br>Dallas, Texas 75248 | MDR Tracking No.: M4-05-3092-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br>Textron, Inc.<br>C/O Broadspire Services, Inc.<br>ATTN: Kim Moore<br>Dallas, Texas 75251<br>Box 47 | Date of Injury:<br>Employer's Name: Textron, Inc.<br>Insurance Carrier's No.: 4660045454 |

## PART II: SUMMARY OF DISPUTE AND FINDINGS

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| **01/06/04** | **01/12/04** | **Surgical Admission** | **$36,891.89** | **$8,219.20** |
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## PART III: REQUESTOR'S POSITION SUMMARY

"It appears this claim meets the stoploss requirement; however, reimbursement does not represent the established methodology. It appears the audit company has only paid the surgical per diems and partial payment toward carved out services."

## 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." 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 operative report indicates that this was a Posterior lumbar interbody fusion. The operative report also indicates there were no complications and patient was brought to the recovery room, alert and oriented.

The carrier made reimbursement based on per diem and carve out of the implantables (6 day stay and cost plus ten percent for the implantables, bringing the total amount of reimbursement to $39,763.00). However, the invoices indicate the amount billed was $37,522.00, of which the carrier reimbursed $33,055.00, the carrier reimbursed incorrectly based on reimbursement of 110%. Therefore, the reimbursement for the implantables should be $37,522.00 x 110% = $41,274.20 plus the 6 day stay $6,708.00(6 x $1,118.00) = a total reimbursement of $47,982.20 - $39,763.00 already paid by the insurance carrier = $8,219.20 in additional reimbursement due.

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 entitled to an additional reimbursement in the amount of $8,219.20.

**PART VI: COMMISSION DECISION**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor **is** entitled to additional reimbursement in the amount of $8,219.20. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20 days of this Order.

**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: _____