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 Rd. Pasadena, TX 77504	MDR Tracking No.: M4-05-3098-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address State Office of Risk Management BOX: 45 P.O. Box 13777 Austin, TX 78711	Date of Injury: Employer's Name: State of Texas Insurance Carrier's No.: WC2104875

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/12/04	01/13/04	Inpatient Hospitalization	$48,837.29	$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

On 01/30/04 the Office received submitted billing from the requestor Vista Medical Center Hospital for the dates of service in question. An audit was performed and reimbursement was issued to the requestor on 03/01/04 in the amount of #3,543.70. In review of the dispute packet the Office found that an overpayment was made for the inpatient surgical per diem rate and reimbursement erroneously made for a radiology charge. The Office's cost containment vendor allowed $1,453.40 for the inpatient surgical per diem instead of the Commission established $1,118.00 per diem rate for surgical stays. A reimbursement of $253.30 was also allowed for the radiology charged billed by the requestor, however based on Commission rules radiology is not considered a reimbursable carve-out…

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." The claimant was admitted for a decompressive procedure. This was carried out uneventfully on 1/12/04. The claimant recovered uneventfully and was discharged the following day. 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 1 day (consisting of 1 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $1,118.00 (1 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor submitted and implant invoice from NuVasive in the amount of $1,674.00; this amount times 10% equals $1,841.40. Per Diem rate of $1,118.00 plus implantables in the amount of $1,841.40 equals a reimbursement of $2,959.40.

The insurance carrier reimbursed the healthcare provider a total of $3,290.40. 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 12, 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 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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____