

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC		<b>Response Timely Filed?</b> (X) Yes ( ) No	
Requestor's Name and Address T. Daniel Hollaway, Attorney On behalf of HCA Corpus Christi Medical Center 3701 Kirby Drive, Suite 1288 Houston, TX 77098-3926		MDR Tracking No.: M4-05-3681-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address American Casualty Company c/o H. Douglas Pruett, Attorney 6836 Austin Center Blvd., Suite 280 Austin, TX 78731		Date of Injury:	
		Employer's Name: First South Utility Construction	
		Insurance Carrier's No.: 3C805204	

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/22/04	01/26/04	Inpatient Surgical	\$42,461.75	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

Requestor provided bill requesting total reimbursement based on stop-loss reimbursement methodology. \$73,737.00 (Total billed) X SLRF 75% = \$55,302.75 (Total allowable.)

## PART IV: RESPONDENT'S POSITION SUMMARY

The carrier reimbursed \$44,72.00 on 2-24-04 for inpatient hospital stay and a supplemental reimbursement for implants of \$8,369.00 on 4-16-04 for a total of \$12,841.00. Carriers' position is that the provider did not meet the requirements under the stop-loss reimbursement method or that the services provided were unusually costly.

## 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."

The surgical intervention involved in this particular admission included a single level lumbar decompression and fusion. It is also noted that the discharge summary states:

The patient underwent uncomplicated surgery the same day of admission, was discharged to the floor, was mobilizing quite well on the floor. Postoperatively, he was discharged to home with a walker and home health care. He will follow up in my clinic in two weeks' time.

After reviewing the documentation 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 under the per diem methodology.

The total length of stay for this surgical admission was 4 days. Accordingly, the standard per diem amount due for this admission is equal to \$4,472 (4 X times \$1,118). In addition, the requestor indicated implant charges totaling \$27,502.11 but did not provide adequate documentation to determine the actual cost of implantables or how their charges were derived.

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, which included reimbursement of \$8,369.00 for implants under revenue code 278, 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:

Allen McDonald

May 2, 2005

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, Mail Stop 35, 7551 Metro Center Dr., 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 in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_