## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION				
Type of Requestor: ☐ HCP ☐ IE ☐ IC	Response Timely Filed?			
Requestor's Name and Address Houston Community Hospital	MDR Tracking No.: M4-05-4222-01			
P. O. Box 11586	TWCC No.:			
Houston, TX 77293-1586	Injured Employee's Name:			
Respondent's Name and Address TPCIGA FOR RELIANCE NATIONAL INDEMNITY	Date of Injury:			
9120 BURNET RD AUSTIN TX 78758-5204	Employer's Name: Vitas Healthcare Corp.			
Austin Commission Representative Box 50	Insurance Carrier's No.: 900000199			

#### PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To	of 1 couc(s) of Description	rimount in Dispute	7 mount Duc
4/23/04	5/01/04	Inpatient Hospitalization	\$125,854.54	\$57,923.04

### PART III: REQUESTOR'S POSITION SUMMARY

...We are requesting that TPCIGA for Reliance National IND pay our claims at the usual and customary.

## PART IV: RESPONDENT'S POSITION SUMMARY

Provider's dispute should be dismissed pursuant to Commission rule 133.307(m) because it has not complied with rule 133.304(k)(3). Specifically, Provider's request for reconsideration did not provide any substantive rebuttal of TPCIGA's reasons for reduction of payment. For example, Provider did not explain why it believes its charges, as billed, are usual and customary and why TPCIGA's reductions are not accurate. Therefore, Provider's bill has not been properly submitted and the request for medical dispute resolution should be dismissed pursuant to Commission rule 133.307(m). Even if this dispute were considered. Provider is not entitled to additional reimbursement for the disputed services.

First, this case did not meet the requirements for reimbursement under the stop-loss provisions and therefore, Provider has already been overpaid. In order to qualify for stop-loss reimbursement, the two criteria that must be met are that: (1) the audited charges must exceed \$40,000; and (2) the services provided should be unusually extensive and costly. Although Provider's grossly inflated charges exceed \$40,000, there is no evidence that the services provided were unusually extensive and costly. Specifically, there is no evidence that the patient had co-morbidities or complications that required unusually extensive services or that any such services were unusually costly. The evident shows only that the Provider's charges were unusually inflated. According to the records, this was a planned procedure; there were no complications; the patient tolerated the procedure well and was taken to the recovery room in good condition.

Second, even if the stop-loss method were applicable to this case, Provider has already been properly reimbursed under the stop-loss provisions. Provider has not met its burden of proof to establish that its billed charges were usual and customary, as the term has been defined. See, e.g., UTMB v. TPCIGA, MDR Tracking No. M4-03-1203-01 (Feb. 9, 2004) ("The explanation letters regarding Corvel's audit show that usual and customary was evaluated. It doesn't appear that the request attempted to rebut these reductions with anything more than the stop loss rule. On this basis, the insurance carrier is correct and the stop-loss was properly applied.")

TPCIGA reduced Provider's grossly inflated charges to the usual and customary amount....In conclusion, Provider has been reimbursed 75% of the usual and customary amount for its billed charges. Therefore, it is not entitled to additional reimbursement.

Finally, the stop-loss provisions of the guideline, as interpreted by Provider, are invalid for the reasons stated above. Therefore, reimbursement would be a fair and reasonable amount, as determined in accordance with the statutory standards for reimbursement under the Act. Provider has already been paid a more than fair and reasonable amount in this case.

# 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** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 8 days based upon spinal surgery involving the following

procedures: Removal of Synthes Click'X system from the lumbar spine; Removal of EBI battery pack; Exploration of fusion of L5-S1; Extension of fusion to L4; Re-instrumentation of a Blackstone lumbar instrumentation L4-S1, a re-do decompression of L4-5 and L5-S1; Iliac crest bone graft, right side, through a separate incision; Use of Allograft bone and DBX putty; Fusion L4-S1; Screw test utilizing the SSEP monitors X 8; Planned sceond stage of a 2-stage surgery for stabilization of the joints at a level of L4-L5; Laparotomy, retroperitoneal dissection and mobilization of abdominal aorta and left iliac vein and artery and inferior nena cava, exporsure of L4 and L5 vertebral body and intervertebral disc space; and insertion of left subclavian triple-lumen central venouse catheter. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding the charges for the implantables. The requestor billed \$74,710.00 for the implantables. The carrier paid \$23,861.25 for the implantables based on a cost plus 10% approach. The key issue is what amount would represent the usual and customary charges for these implantables in determining the total audited charges. The requestor provided the Commission with invoices in the amount of \$23,195.00 for the actual cost of implantables. Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%. Since the actual cost of the implantables is \$23,195.00 based on invoices supporting their cost or charge, we will apply this average mark-up to the cost amount to determine the amount to use in the total audited charges. Based on a cost of \$23,195, d this amount multiplied by the average mark-up of 200% results in an audited charge for implantables equal to \$46,390.00

The total audited charges associated with this admission equals \$158,390.00. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to \$118,792.50. The Requestor billed the Respondent \$186,724.00 and received payments of \$60,869.46.

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 a reimbursement amount for these services equal to \$57,923.04.

## PART VI: COMMISSION DECISION AND ORDER

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 \$57,923.04. 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 receipt of this Order.

Ordered by:		
	Allen McDonald	04/13/05
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:		