

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.:	M4-05-4716-01
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address National Surety Corporation Box 19 c/o Flahive, Ogden & Latson 505W. 12 th St. Austin, TX 78701		Date of Injury:	
		Employer's Name:	Texas Health Resources
		Insurance Carrier's No.:	67099915544

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/28/04	05/03/04	Inpatient Hospitalization	\$40,801.77	\$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

Here, the initial \$40,000 threshold has not been exceeded. The "total charges" less "deducted charges" (including personal items, undocumented services, services unrelated to the compensable injury, duplicative charges, upcoded services, unbundled services, implantables, orthotics, prosthetics and pharmaceuticals in excess of \$250 per does), results in "audited charges" which do not exceed \$40,000. Cost-plus reimbursement for the above referenced services is applicable as such are included in "deducted charges"... In addition, only a three-day inpatient stay was preauthorized. Claimant stayed an additional two days, but those two additional days were not concurrently authorized as required in Rule 134.600(i). Since those additional two days were not concurrently authorized, Carrier is not liable for those healthcare services.

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 a two-level hemilaminectomy to decompress the spinal stenosis at L4-5 and L5-S1, as well as bilateral diskectomies at L4-5 and L5-S1. Throughout the patients hospital stay, she remained afebrile. The patient continued, however, on the IV antibiotics and oral antibiotic prophylactic treatment until the day of discharge. The patients ambulatory habits were limited, as it took a great deal of effort to get the patient to ambulate secondary to the medications, but also secondary to the patient's noncompliance. The JP drain was removed on the fourth postoperative day after it met criteria of 24 hours less than 300 cc drainage. The incision site was clean with minimal serous, colored drainage from the site where the JP had been pulled. There is no evidence of surrounding infection or swelling in the surgical region. The assessment at discharge was "status post successful surgical procedure, with significant improvement compared to her preoperative assessment"... 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 5 days (consisting of 5 days for surgical). However, preauthorization was obtained for a 3-day stay. Accordingly, the standard per diem amount due for this admission is equal to \$3,354.00 (3 times \$1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: According to the UB-92 implantables were not used for this surgical admission.

The insurance carrier reimbursed the healthcare provider \$3,354.00. 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 esta 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: _____