Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: HCA Healthcare 6000 NW Parkway, Suite 124 San Antonio, Texas 78249	MDR Tracking No.: M4-05-6104-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Twin City Fire Insurance Company Box 27	Date of Injury: Employer's Name: City of Laredo Insurance Carrier's No.: A0792138A

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle documentation:

1. A discharge summary
2. Invoices
3. Position statement noted in the case file.

"Per TWCC guidelines total charge exceed $40K, therefore stoploss applies. Implants are not considered auditable."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle documentation:

1. A position statement.

"This is a medical dispute arising from an inpatient hospital surgical admission, dates of service 08/24/2004 to 08/28/2004. Requestor billed a total of $64,661.14. The Requestor asserts it is entitled to reimbursement in the amount of $48,495.86, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
08/25/04-08/28/04	Surgical Admission	I & II	$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

I. 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."

II. After reviewing the information provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." The provider submitted an operative report indicating that a posterior lumbar interbody fusion at L4-L5 and the

discharge summary did not indicate any complications. Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem methodology plus carve-outs described in the same rule.

Requestor billed $64,661.14 for the 3-day hospital stay per the UB-92.

The carrier made reimbursement for the 3-day stay in the amount of $17,599.00 per the submitted EOBs.

Per diem for the 3-day stay are $3,354.00 ($1,118.00 x 3) and cost plus ten percent for the implantables. The provider submitted an invoice indicating the cost of $7,950.00 for the implantables. Per diem for the 3-day stay $3,354.00 and cost plus ten percent for the implantables $8,745.00 ($7,950.00 x 110% = $8,745.00) + $3,354.00 per diem = $12,099.00 recommended reimbursement. The carrier reimbursed the provider $14,245.00 for the implantables and $3,354.00 per diem, bringing the total reimbursement to $17,599.00 per the submitted EOBs, leaving no additional reimbursement recommended.

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 not entitled to additional reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.401 (c)(6).

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor **is not** entitled to additional reimbursement.

Ordered by:

	Michael Bucklin	05/24/06
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.