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) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes ()No
Requestor Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M4-05-6593-01 TWCC No.: Injured Employee's Name:
Respondent's TASB Risk Management Fund Rep. Box # 12	Date of Injury: Employer's Name: Rankin ISD Insurance Carrier's No.: 0250011021796343

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4-8-03	4-10-03	Inpatient Hospitalization	$31,603.48	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

"Payment not in accordance with Acute In-Patient Fee Guideline for charges above 40K threshold. Code improperly used to designate Acute In-Patient Stop Loss per Fee Guideline Reimbursement."

Principle Documentation:

1. Requestor's position statement
2. Operative Report
3. EOB
4. UB-92

PART IV: RESPONDENT'S POSITION SUMMARY

"Section 413.011(b) of the Labor Code states in part that guidelines for medical services must be fair and reasonable and designed to achieve effective medical cost control. Payment to the requestor based on stop-loss methodology when the stop-loss threshold was bridged because of an unsubstantiated markup increases associated with implant supplies, for unknown reasons, is not fair to the carrier or the policy-holder, is not reasonable, and is inconsistent with effective medical cost control. To pay the requestor a stop-loss payment violates this section of the Labor Code. As such the TASB cannot authorize additional payment for the disputed services."

Principal Documentation:

1. Respondent's position statement

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."

Operative report indicates claimant underwent C5-6 to C6-7 partial corpectomy, osteophytectomy; anterior cervical fusion C5-6 to C6-7 with instrumentation.

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 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 2 days (consisting of 2 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $2236.00 (2 times $1,118.00). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

Cost invoices support charges of $3,990.00. The Medical Review Division considers fair and reasonable reimbursement to be cost + 10% for implantables, resulting in a reimbursement for implantables of $4,389.00.

The charge for surgical admission of $2236.00 + $4,389.00 for implantables = $6,625.00.

The insurance carrier paid $6,625.00 for the inpatient hospitalization.

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 additional reimbursement is not 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:

	Elizabeth Pickle	June 6, 2006
Authorized Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

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.

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: _____