AMENDED 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 Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M4-05-6950-01 **(PREVIOUSLY M4-04-A768-01)** TWCC No.: Injured Employee's Name:
Respondent's Name and Address Houston I.S.D. c/o Harris & Harris Box 42	Date of Injury: Employer's Name: Houston I.S.D. Insurance Carrier's No.: 023110000015290001

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/22/03	**09/25/03**	**Inpatient Hospitalization**	**$66,432.52**	**$8,430.50**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary states in part, "…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 increases 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

Position Summary states in part, "…To invoke the Stop-Loss reimbursement provisions, the Requestor must meet two criteria: (1) the audited charges must exceed $40,000, the minimum stop-loss threshold, and (2) the services made the basis of the charges must be unusually extensive/costly. Nowhere in any of the submitted documentation does the Requestor indicate the services were unusually extensive or costly. Nothing in the documentation describes complications of any nature; nothing shows the procedure was anything but routine. While the Requestor did bill over $40,000 for its services, it has not shown the procedure to be either unusually costly or extensive. As such, it has failed to meet the two-pronged Stop-Loss criteria, and merits no additional monies…"

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

This Amended Findings and Decision supersedes all previous Decisions rendered in this Medical Payment Dispute involving the above Requestor and Respondent. The Medical Review Division's Decision of 04/15/05 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 05/19/05. An Order was rendered in favor of the Requestor. The Requestor appealed the Order to an Administrative Hearing as the Requestor did not agree with the disposition of this dispute that resulted in the withdrawal of the Findings and Decision of M4-04-S768-01.

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 appears that this particular admission involved "unusually extensive services." However, according to the carrier's response, they are questioning usual and customary for the charges. Without further explanation from the requestor to refute this audit question, MDR is unable to order additional reimbursement beyond three days per-diem.

The total length of stay for this admission was 3 days (consisting of 3 days for surgical). 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:

DePuy AcroMed:	$4,615.00 X 10% = $5,076.50
Per Diem:	3,354.00
Total Reimbursable Amount:	$8,430.50

The Requestor billed $88,576.69; the Respondent did not reimbursement the hospital.

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 $8,430.50

PART VI: AMENDED 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 $8,430.50. 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.

Amended Ordered by:

	James Schneider	May 2005
Authorized Signature	Typed Name	Date of Order

Amended Decision by:

	Marguerite Foster	May 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 Amended 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 Amended Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Amended Decision is deemed received by you five days after it was mailed and the first working day after the date the Amended 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 Amended Decision should be attached to the request.

The party appealing the Division's Amended 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 Amended Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____