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.: M4-05-6951-01 **(Previously M4-04-B143-01)** TWCC No.: Injured Employee's Name:
Respondent's Name and Address Continental Casualty Co. c/o Burns, Anderson, Jury & Brenner Box 47	Date of Injury: Employer's Name: Schwan Food Co. Insurance Carrier's No.: 3A069571

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/14/04	01/18/04	Inpatient Hospitalization	$98,328.67	$0.00

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, "…Vista is seeking reimbursement under the Stop-Loss method because its billed services exceed $40,000.00. However, most of the services for which it has billed do not have an assigned reimbursement rate by the TWCC. Vista has failed to submit any documentation, as required by TWCC rule, establishing that its charges for these services are reasonable and necessary. Therefore, its request for Medical Dispute Resolution must be dismissed…"

PART V: 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 The Medical Review Division's Decision of 03/15/05 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 04/13/05. An Order was rendered in favor of the Requestor. The Respondent appealed the Order to an Administrative Hearing as the Respondent did not agree with the disposition of this dispute that resulted in the withdrawal of the Findings and Decision of M4-04-B143-01.

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 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 4 days (consisting of 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $4,472.00 (4 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

DePuy Spine, Inc.	$19,341.00	Implantables:	$21,275.10
10%	1,934.10	Per Diem:	4,472.00
Cost plus 10%:	$21,275.10	Total Reimbursement:	$25,747.10
		Less IC Payment:	($27,366.53)
		Amount:	($ 1,619.53)

The Requestor's table reported payment of $6,901.43 and provided a copy of a check stub reflecting $21,275.10. The Response indicates $27,366.53 was paid.

The carrier has made additional and confusing payments for pharmacy and blood products. They reference a contract as the reduction reason. The Requestor denies the proper application of the contract in the audit. Without a copy of the contract MDR is unable to address the terms of the contract as it may apply to this dispute. Considering calculation of per-diem and the carrier's payments previously made, MDR is unable to order additional reimbursement.

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 **not** entitled to additional reimbursement.

Amended Decision by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	June 1, 2005

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 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: _____