MEDICAL DISPUTE RESOLUTION AMENDED FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (X) No
Requestor Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M4-05-6954-01 TWCC No.: Injured Employee's Name:
Respondent's State Farm Fire & Casualty Co. Rep. Box # 21	Date of Injury: Employer's Name: United Air & Heat Insurance Carrier's No.: 53W515333

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2-10-03	2-15-03	Inpatient Hospitalization	$52,229.29	$6,811.50

PART III: REQUESTOR'S POSITION SUMMARY

F – Payment not in accordance with Acute In-Patient Stop Loss per Fee Guideline; and M – Code used improperly to designate reimbursement pursuant Acute In-Patient Stop Loss per Fee Guideline; and N – Carrier did not forward and explanation of missing documentation within 14 days in compliance with Texas Administrative Code.

PART IV: RESPONDENT'S POSITION SUMMARY

State Farm Insurance Company has paid in appropriate payment for the health care treatments/services billed by the health care provider.

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

This AMENDED FINDINGS AND DECISION supersedes M4-04-5480-01 rendered in this Medical Payment Dispute involving the above requestor and respondent.

The Medical Review Division's Decision of 3-3-05 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 3-30-05. The original decision and order erroneously ordered additional payment for date of service that were not preauthorized.

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 5 days. The UB92 and discharge report do not support any complicating factors in the course of the 5-day inpatient stay to support a medical emergency to exceed the approved 2 days. Accordingly, the standard per diem amount due for this admission is equal to $2,236.00(2 times $1,118.00). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

TMC Orthopedic $1025.00 X 10% = $1127.50.
TMC Orthopedic $8225.00 X 10% = $9,047.50.

TOTAL of Invoices = $10,175.00

TOTAL of Invoices and Per Diem/ Surgery $10,175.00 + $2,236.00 = $12,411.00.

The insurance carrier paid $5,599.50 for the inpatient hospitalization. The difference between amount paid and amount due = $6,811.50.

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 $6,811.50.

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 entitled to additional reimbursement in the amount of $6,811.50. 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.

Decision by:

	Elizabeth Pickle	May 10, 2005
Authorized Signature	Typed Name	Date of Order

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 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 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 CERTIFICATION000000

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: _____