AMENDED MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Rd. Pasadena, Texas 77503	MDR Tracking No.: M4-05-8144-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Travelers Indemnity Co. of Conn./Rep. Box #: 05 C/o The Travelers Companies 1501 S. MoPac Expy., Ste. A-320 Austin, Texas 78746	Date of Injury: Employer's Name: Baylor Methodist Primary Care Insurance Carrier's No.: 478CBBUG1419

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2-14-03	3-7-03	Inpatient Hospitalization	$134,775.94	$100,265.01

PART III: REQUESTOR'S POSITION SUMMARY

Position statement of February 17, 2004 states "…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… In this instance, the audited charges that remained in dispute after the last bill review by the insurance carrier were $285,476.41. The prior amounts paid by the carrier were $77,603.05. Therefore, the Carrier is required to reimbursement the remainder of the Workers' Compensation Reimbursement Amount of $134,775.94, plus interest…".

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement was not submitted.

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

Due to a calculation error in MDR Tracking #: M4-04-5747-01, the case is withdrawn under a Notice of Withdrawal of Findings and Decision signed on May 17, 2005. An Amended Findings and Decision is issued under MDR Tracking #: M4-05-8144-01.

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 the Requestor, it **does** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 21 days based upon lumbar fusion L3-S1 decompression, instrumentation, graft and pain pump and deep wound infection. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding the charges for the implantables. The requestor billed $83,139.00 for the implantables. The carrier paid $22,065.84 for the implantables. The key issue is what amount would represent the usual and customary charges for these implantables in determining the total audited charges. The requestor provided the Commission with documentation on the actual cost of implantables, $17,410.00.

Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%. This amount multiplied by the average mark-up of 200% results in an audited charge for implantables equal to $34,820.00.

The audited charges for this admission, excluding implantables, equals $202,337.41. This amount plus the above calculated audited charges for the implantables equals $237,157.41, the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to $100,265.01 ($177,868.06 -$77,603.05 (amount paid by respondent)).

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 $100,265.01.

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 $100,265.01. 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.

Ordered by:

	Robert L. Shipe	5-20-05
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 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, 7551 Metro Center Drive, Suite # 100, 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: _____