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) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Twelve Oaks Medical Center C/o Hollaway & Gumbert 3701 Kirby Dr., Suite 1288 Houston, TX 77098	MDR Tracking No.: M4-05-9258-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Interstate Ins./Rep. Box #: 01	Date of Injury: Employer's Name: Crumplers Inc Insurance Carrier's No.: 200227440TX

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary as stated on the Table of Disputed Services, "Carrier didn't pay the claim at usual & customary. Hospital is requesting we be reimbursed at usual & customary. Carrier Denied Request for Reconsideration Stop Loss not applies."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary as stated on the Table of Disputed Services, "provider has not proven unusually costly or extensive services. Post-op reports list no complications patient ambulating on post-op #1, nurse discharge status "no needs identified." Per TWCC decisions, charges that exceed $40,000 do not automatically qualify for stop loss."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
6-4-04 – 6-7-04	Inpatient Hospitalization	1	$44,135.82

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

1 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** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of three days based upon "… removal of anterior cervical hardware, exploration of anterior cervical fusion mass C4 – C5, C6 – C7, anterior cervical decompression of spinal cord nerve root C6 – C7, anterior cervical fusion C4 – C7, and posterior cervical fusion and instrumentation C4 – C7." Accordingly, the stop-loss method does apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

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 $41,949.60 for the implantables. The carrier paid $5,290.12 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, $13,982.40

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 $27,964.80.

The audited charges for this admission, excluding implantables, equals $42,408.45. This amount plus the above calculated audited charges for the implantables equals $70,373.25 the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to $44,135.82 ($52,779.94-$8,644.12 (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 $44,135.82.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.401(c)(6)

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of $44,135.82. 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 30-days of receipt of this Order.

Ordered by:

	Allen C. Mc Donald, Jr.	1-2-06
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

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.