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 Drive, Suite 1288 Houston, Texas 77098	MDR Tracking No.: M4-05-A185-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Albertson's, Inc. Box 19	Date of Injury: Employer's Name: Albertson's, Inc. Insurance Carrier's No.: 99000663

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle documentation:

1. An operative report.
2. History & Physical.
3. A position statement.

"As stated above, our client does not agree with the position of the insurance carrier and is seeking assistance from Medical Dispute Resolution in order to resolve this issue."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle documentation:

1. A Position statement.

"At this original submission the invoices supplied did not match up with what the requestor was billing for implants on the itemized statement. At that time the invoices that were valid were reimbursed at an amount of $1,298.49. On 08/02/05, these charges were reconsidered and a supplemental payment of $8,066.91 was made for the implants."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
07/07/04-07/10/04	Surgical Admission	I & II	$0.00

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

I. 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 additional 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."

II. After reviewing the information provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." The provider submitted an operative report indicating removal of posterior instrumentation, exploration of fusion mass and fusion of the lumbar spine from L4 to S1 was performed, the operative report did not indicate any complications and the patient was transferred to a bed in recovery room in satisfactory condition. Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem methodology described in the same rule.

Requestor billed $51,699.75 for the 3-day hospital stay per the UB-92.

The carrier made reimbursement for the 3-day stay in the amount of $11,010.00.

Per diem for the three day stay is $3,354.00 ($1,118.00 x 3). The carrier reimbursed the provider $3,354.00 for 3-day stay per diem and $7,656.00 for supplies/implants revenue code 278, for a total of $11,010.00, leaving no additional reimbursement recommended.

Therefore, 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 not entitled to additional reimbursement.

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 not** entitled to additional reimbursement.

Ordered by:

	Michael Bucklin	05/10/06
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.