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: Vista Hospital of Dallas 4301 Vista Road Pasadena, Texas 77504	MDR Tracking No.: M4-05-A477-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TPCIGA for Reliance National Indemnity 9120 Burnet Road Austin, Texas 78758-5204 Box 50	Date of Injury: Employer's Name: Maxim Healthcare Services, Inc. Insurance Carrier's No.: 690C 87169

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted invoices for the implantables, operative report and discharge summary. Requestor submitted operative report, discharge summary and a position statement. The requestor indicates in their position statement that, "As discussed in this decision, there is no evidence or denials presented by the Carrier that the prices billed were not Provider's usual and customary charges (which the Hospital must bill under Commission's rules), that the price markup was not consistent with the geographical or other hospital billing practices, or that the final price was not fair and reasonable." Requestor is requesting additional reimbursement in the amount of $59,695.95.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Acts and Rules." Carrier asserts that the Requestor is not due any additional reimbursement.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
08/20/04-08/24/04	Surgical Admission		

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

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."

After reviewing the information provided by the provider, it does **not** appear that this particular admission involved "unusually extensive services." The requestor submitted an operative report indicating that an exploration of cervical fusion at C5-6 and C6-7 and augmentation of the fusion with some Helio synthetic bone was performed. The patient left the OR in good condition and no complications were noted. 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 carrier made reimbursement for the 3-day stay in the amount of $3,017.10.

The requestor billed $2,840.00 for the implantables.

The requestor submitted an invoice indicating the cost for the implantables were $710.00.

Therefore, reimbursement based on per diem is $2,236.00(2 x $1,118.00) and reimbursement for the implantables at cost plus ten percent is $781.00 ($710.00 x 110%). Per diem for the 2-day stay is $2,236.00(2 x $1,118.000) + $781.00 for the implantables = $3,017.00, 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	09/09/05
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.