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-A486-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Ins. Co./Rep. Box #: 54	Date of Injury: Employer's Name: Greenridge Townhouse Insurance Carrier's No.: 99D0000340652

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary as stated on the Table of Disputed Services, ", "IC failed to pay per TWCC TWCC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline and SOAH decision 453-04-36--.M4. Per TWCC Rule 134.401(c)(6) and SOAH decision 453-04-3600.M4. claim pays @ 75% of total charges as charges exceed $40,000 stop-loss threshold. IC further failed to audit according to TWCC Rule 134.401(c)(6)(A)(v). Further, services were unusually extensive based on 9 surgical procedures related to IE's spinal surgery; IE treated for recurrent disk herniation L4-5."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary of August 1, 2005 states, "…The dispute involves this carrier's payment for dates of service in dispute for which the requester charged $77,134.33 for a four day inpatient stay for services that were NOT unusually extensive or costly. This carrier reimbursed the requester for two days surgical per diem ($1,118) per the TWCC Acute Care In-Patient Fee Guideline. The requester was also reimbursed cost plus 10% 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)
7-19-04 – 7-23-04	Inpatient Hospitalization	1	$00.00

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 **not** appear that this particular admission involved "unusually extensive services." The patient underwent a one level diskectomy, laminectomy, posterior interbody fusioins with instrumentation under fluoroscopic control. 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 4 days (consisting of 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $4,472.00(4 days times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor submitted an invoice for implantables totaling $10,978.00.

Total of Implantables: $10,978.00 x 10% = $12,075.80 Total audited charges: $4,472.00 + $12,075.80 = $16,547.80

The Requestor billed $77,134.33; the Respondent reimbursed the healthcare provider $16,559.20.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION DECISION

Based upon the review of the disputed healthcare services, the Division has determined that the requestor is **not** entitled to additional reimbursement

Findings and Decision by:

	Roy Lewis	2-3-06
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.