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: Memorial Hermann Hospital System 3200 S.W. Freeway, Ste. 2200 Houston, TX 77027	MDR Tracking No.: M4-05-A513-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Co./Rep. Box #: 19	Date of Injury: Employer's Name: Trimac Corp. Insurance Carrier's No.: 077089685

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary as stated on the Table of Disputed Services, "Patient required unusually extensive services exceeding the stop loss threshold of the ACIHFG and should have been paid at 75% of billed charges."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary of August 8, 2005 states, "…There is no evidence submitted by the hospital demonstrating that the services provided by the hospital were unusually extensive. There is no evidence of "complications, infections, or multiple surgeries" requiring additional services by the hospital. There is no evidence that services provided by the hospital were unusually costly to the hospital… The Hospital has failed to meet all of these burdens – they have simply failed to document entitlement to any payment. The Hospital has not even submitted an operative report. The bill has no documentation and was properly denied…"

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
7-22-04 – 7-24-04	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 UB-92 list the "Principal Procedure" as "81.08", lumbar and lumbosacral fusion, posterior technique. 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 2 days (consisting of 2 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $2,236.00 (2 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 however; the operative report for 7-22-04 to 7-24-04 (disputed dates of service) was not submitted. The operative report submitted appears to be for 9-4-03.

The Respondent denied the inpatient hospitalization with denial code "N" on the explanation of benefits. This reason appears to be sufficient for the purposes of rule 133.304(c). As stated in the Respondent's position summary of August 8, 2005, "The Hospital has not even submitted an operative report. The bill has no documentation…"

The Requestor bill $49,913.75. The Respondent did not allow any reimbursement.

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 reimbursement is due for these services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.401(c)(6)
28 Texas Administrative Code Sec. 133.304 (c)

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	1-24-06
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.