



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Vista Hospital of Dallas 4301 Vista Pasadena, Texas 77504	MDR Tracking No.: M4-05-A520-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Insurance Company of the State of PA Box 19	Date of Injury:
	Employer's Name: Wal Mart Stores, Inc.
	Insurance Carrier's No.: 98055608

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle documentation:

1. An operative report
2. A discharge summary
3. A position statement.
4. Invoices

“As discussed in this decision, there is no evidence or denials presented by the Carrier that the prices billed were not Vista’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.”

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle documentation:

1. A Position statement.

“As a result of this review, no further payment was recommended towards the amount in dispute.”

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
08/11/04-08/14/04	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 that an exploration of left facet fusion at L5-S1, removal of pedicle screw fixation at L5-S1 and implantation of Marcaine pain pump was performed, the operative report did not indicate any complications and left the OR in good condition. Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem methodology plus carve-outs described in the same rule.

Requestor billed \$52,462.64 for the 3-day hospital stay per the UB-92.

The carrier made reimbursement for the 3-day stay in the amount of \$33,747.12 per the submitted EOBs.

Per diem for the three day stay is \$3,354.00 (\$1,118.00 x 3) and cost plus ten percent for the implantables. The provider submitted invoices indicating the cost of \$1,380.00 for the implantables. Per diem for the three day stay \$3,354.00 and cost plus ten percent for the implantables \$1,518.00 ($\$1,380.00 \times 110\% = \$1,518.00$) + \$3,354.00 per diem = \$4,872.00. The carrier reimbursed the provider \$33,747.12, 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

04/19/06

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.