



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-A526-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: Texas Mutual Insurance Company Box 54 | Date of Injury: |
| | Employer's Name: Green Lake Nursery, Inc. |
| | Insurance Carrier's No.: 9900000230634 |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle documentation:

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

“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. Position statement noted in the case file.

“The requester charged \$40,961.49 for a two day inpatient stay for services that were NOT unusually extensive or costly. This carrier reimbursed the requester two days surgical per diem based on the TWCC Acute Care In-Patient Fee Guideline. The requester has not argued that the services were unusually costly or extensive, just that they billed over \$40,000, as you can see in the requester’s TWCC 60 packet.”

PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | CPT Code(s) or Description | Part V Reference | Additional Amount Due (if any) |
|--------------------|----------------------------|------------------|--------------------------------|
| 08/24/04-08/26/04 | 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 explantation of pedicle fixation and evaluation of fusion integrity was performed; the operative report did not indicate any complications. 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 \$40,961.49 for the 2-day hospital stay.

The carrier made reimbursement for the 2-day stay in the amount of \$2,236.00.

Per diem for the two day stay (surgical) is \$2,236.00 (\$1,118.00 x 2). The carrier made reimbursement in the amount of \$2,236.00, 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

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.