

## 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	
<b>Type of Requestor:</b> (x) Health Care Provider () Injured Employee	() Insurance Carrier
Requestor's Name and Address: Vista Medical Center Hospital	MDR Tracking No.: M4-05-A568-01
4301 Vista	Claim No.:
Pasadena, Texas 77504	Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Company	Date of Injury:
P O Box 13367 Austin, Texas 78711-3367 Box 19	Employer's Name: ISI Specialists, Inc.
	Insurance Carrier's No.: 2230110292

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted operative report, discharge summary and invoices. 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."

### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier submitted a position statement that supports their reason for no additional reimbursement. "The Requestor asserts it is entitled to reimbursement in the amount of \$62,017.25, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges. The Hospital claims entitlement for implantables. There is NO evidence that implantables were utilized in the surgery! Provider apparently claims that the 'neuro vision module' was an 'implant', and that it may be billed. Yet they have not documented this in the materials provided to the Carrier. There is no evidence supporting a separate billing (in the amount of \$12,213.00) for this item. There is no proof of the efficacy of this so called module. In absence of documentation, this line item should be denied."

PART IV: SUMMARY OF DISPUTE AND FINDINGS				
Date(s) of Service	<b>CPT</b> Code(s) or Description	Part V Reference	Additional Amount Due (if any)	
08/04/04-08/05/04	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 provider submitted an operative report indicating that a left lumbar with diskectomy and foraminotomy, L5-S1 was performed, the patient was taken to the recovery room 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 methodology described in the same rule.

Provider billed a NeuroVision Module and Screw test along with a Sterile Pedicle Probe in the amount of \$6,680.00. However the operative report does not indicate that any implantables were used in the surgical procedure. Therefore, they will not be reviewed in this decision.

Requestor billed \$63,605.36 for the one day-stay.

The carrier made reimbursement for the 1-day stay in the amount of \$1,118.00 and blood administration in the amount of \$224.25, making a total reimbursement in the amount of \$1,342.25.

Therefore, reimbursement based on per diem is \$1,118.00(1 x \$1,118.00), leaving no additional reimbursement recommended.

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 JU	UDICIAL REVIEW	
	cisions and orders are procedurally made dire	•

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.