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: Renaissance Hospital P.O. Box 11586 Houston, TX 77293	MDR Tracking No.: M4-05-A846-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Ins. Co./Rep. Box #: 28	Date of Injury: Employer's Name: HB Zachry Co. Insurance Carrier's No.: 949673596

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary of December 14, 2004 states "…the carrier has not offers sufficient evidence to justify or explain the case specific methodology that was used in this particular case: rather, it would appear that the carrier is improperly reducing reimbursement using standard rate of reimbursement that it applies to all cases…"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary of August 17, 2005 states, "…Liberty Mutual does not believe that Renaissance Hospital is due any further reimbursement for services rendered…"

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
9-10-04 – 9-14-04	Inpatient Hospitalization	1	$5,275.08

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 operative reports that the patient underwent a bilateral posterior cervical laminectomy C5-6, C6-7 posterior fusion with screws and rods. "The patient was brought to the recovery room in stable condition. There were not complications". 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 2 days for surgical and 2 days for ICU). Accordingly, the standard per diem amount due for this admission is equal to $5,356.00 (2 days times $1,118 and 2 days times $1,560). 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 $7,986.00.

Total of Implantables: $7,986.00 x 10% = $8,784.60 Total audited charges: $5,356.00 + $8,784.60 = $14,140.60

The Requestor bill $86,069.90. The Respondent reimbursed $8,865.52.

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 we find that the health care provider is entitled to an additional reimbursement amount for these services equal to $5,275.08 ($14,140.60 - $8,865.52)

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 entitled to additional reimbursement in the amount of $5,275.08. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

	Roy Lewis	1-25-06
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.