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, Texas 77293	MDR Tracking No.: M4-05-A858-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company 6210 East Highway 290 Austin, Texas 78723-1098 Box 54	Date of Injury: Employer's Name: North Shore Supply Company, Inc. Insurance Carrier's No.: 99D0000347837

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted an operative report, discharge summary and position statement. Requestor indicates in their position statement; "Carrier did not pay claim at the TWCC Stop Loss. Hospital is requesting we be reimbursed per stop-loss." Requestor is seeking an additional reimbursement in the amount of $117,946.00.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

This dispute involves this carrier's payment for dates of service in dispute for which the requester charged $150,261.60 for a one day inpatient ICU stay and two day surgical stay for services that were NOT unusually extensive or costly. This carrier reimbursed the requester for one day ICU ($1,560) and two surgical per diem ($1,118) per the TWCC Acute Care In-Patient Fee Guideline. The requester was also reimbursed invoice cost plus 10% for the implantables."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due
11/08/04-11/12/04	Surgical Admission		$80,380.60

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** appear that this particular admission involved "unusually extensive services." The provider submitted an operative report indicating that a posterior and anterior fusion at L3-L4 and L4-L5 was performed; the patient tolerated the procedures well and no complications were noted. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the methodology described in the same rule.

Using the stop-loss methodology the total allowable WCRA is $150,261.60.

The carrier has reimbursed the provider $32,315.60.

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 entitled to an additional reimbursement for these services equal to $80,380.60 (total allowable WCRA $150,261.60 x 75% = $112,696.20 - $32,315.60 already paid = $80,380.60.

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 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** entitled to additional reimbursement in the amount of $80,380.60. 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:

	Allen McDonald	01/17/06
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.