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-A979-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Twin City Fire Insurance Company 9020 II Capital of Texas Highway, Suite 555 Austin, Texas 78759 Box 27	Date of Injury: Employer's Name: Volt Information Sciences, Inc. Insurance Carrier's No.: YBUC 69437

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted an operative report, invoices and discharge summary. "Enclosed are copies of EOB's from other carrier's, which show a higher rate of reimbursement, consistent to our usual and customary. We are requesting that Insurance Carrier pay our claims at the usual and customary." Requestor is seeking an additional reimbursement in the amount of $77,566.71.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier indicates in their position statement: "The hospital fee guideline proves two criteria that must be met for a bill to be reimbursed under this section: (i) the total audited charge for a hospital admission must exceed $40,000 AND (ii) the admission must be one that required 'unusually costly or extensive services.' The stop-loss method should not apply to patients that did not require unusually costly or extensive services, even if the total audited charge exceed $40,000."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
09/24/04-09/27/04	Surgical Admission		$25,155.50

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 an anterior L5-S1 fusion was performed and the patient was transferred 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.

The carrier made reimbursement for the 3-day stay in the amount of $6,848.00.

The requestor billed $38,800.00 for the implantables per their submitted UB-92 revenue code 278.

The Requestor submitted invoices that totaled $26,045.00.

Therefore, reimbursement based on per diem is $3,354.00(3 x $1,118.00) and reimbursement for the implantables at cost plus ten percent is $28,649.50 ($26,045.00 x 110%). Per diem for the 3-day stay is $3,354.00(3 x $1,118.000) + $28,649.50 for the implantables = $32,003.50 - $6,848.00 already paid = $25,155.50 in 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 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 $25,155.50. 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	01/03/06
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.