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: HCA Bayshore Medical Center c/o Hollaway & Gumbert 3701 Kirby Drive, Suite 1288 Houston, Texas 77098-3926	MDR Tracking No.: M4-05-B190-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: ACE American Insurance Company 4404 W William Cannon Road, Suite P-170 Austin, Texas 78749-1524 Box 15	Date of Injury: Employer's Name: Greyhound Lines, Inc. Insurance Carrier's No.: C135C6554933

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted an operative report, invoices, discharge summary and position statement. Requestor indicates in their position statement; "Our client does not agree with the position of the insurance carrier and is seeking assistance form the Medical Dispute Resolution for the disposition of this fee reimbursement dispute in question." Requestor is seeking an additional reimbursement in the amount of $25,616.98.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier indicates in their position statement: "The Carrier maintains that the charges submitted by the provider are excessive and do not meet the criteria established to qualify for the Stop Loss reimbursement method. They have not submitted any documentation that would indicate that this admission involved 'unusually extensive services.' The operative report indicates that the patient tolerated the procedure well and there were no intraoperative complications. This bill includes $56,180.00 in supply/implantables alone. We paid cost + 10% on these based on the invoices provided with the bill. Also there is 1 surgical admission date that was denied for lack of pre-authorization as there were only 3 days inpatient pre-authorized and the provider billed for 4."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
08/09/04-08/13/04	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 bilateral posterolateral fusion at L3-L4 and L4-L5 was performed 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 $20,035.70.

One day was denied for lack of pre-authorization by the carrier and the requestor did not refute this and this one-day will not be reviewed.

The requestor billed $32,272.00 for the implantables per their submitted UB-92 revenue code 278.

The carrier reimbursed the requestor $16,000.00 for the implantables and $639.20 for blood products and $3,354.00 per diem for the 3 day stay.

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 $16,000.00 ($14,545.45 x 110%). Per diem for the 3-day stay is $3,354.00(3 x $1,118.000) + $16,000.00 for the implantables = $19,354.00 = $639.20 for blood products = $19,993.32 = $42.50 subsqt hosp care-day E&M = $20,035.70, 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	09/20/05
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.