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-B251-01 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: Knight Transport, LTD Insurance Carrier's No.: 99B0000303940

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted operative report, discharge summary and a position statement. The requestor indicates in their position statement that, "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 the Insurance Carrier pay our claims at the usual and customary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier submitted a position statement that supports their reason for no additional reimbursement. "This dispute involves this carrier's payment of $5,923.74. The requester charged $48,082.21 or $9,616.44 a day for services that were NOT unusually extensive or costly. Therefore, this carrier reimbursed the requester a fair and reasonable reimbursement for CT scan and 5 days surgical per diem based on the TWCC Acute Care In-Patient Fee Guideline."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
11/03/04-11/08/04	Surgical Admission	I	$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

I. 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 both parties, it does **not** appear that this particular admission involved "unusually extensive services." The provider submitted an operative report indicating that this was a post-operative wound infection, the patient returned to the recovery room in stable 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 described in the same rule.

The carrier made reimbursement for the 5-day stay in the amount of $5,923.74.

The carrier made reimbursement for the 5-day stay in the amount of $5,923.74 per diem. Per diem is based on inpatient stay in the amount of $1,118.00 for each day. Reimbursement is 5 x $1,118.00 = $5,590.00 + 268.35 for CT scan and $65.39 for interest bringing the total amount to $5,923.74.

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	11/21/05
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.