

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: Memorial Herman Hospital System	MDR Tracking No.:	M4-05-B402-01
3200 SW Freeway, Suite 2200	Claim No.:	
Houston, Texas 77027	Injured Employee's Name:	
Respondent's Name and Address: Texas Builders Insurance Company	Date of Injury:	
P O Box 164050 Austin, Texas 78716-4050	Employer's Name:	Tele Temp Personnel, Inc.
Box 01	Insurance Carrier's No.:	8488C

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted operative report and a position statement. The requestor indicates in their position statement "The hospital billed its usual and customary charges in the total amount of \$106,566.25. Due to the unusually extensive services and supplies provided, the hospital's usual and customary charges for room and board, ancillary services, drug charges, and implants exceeded the stop-loss threshold under Rule 134.401 (c)(6). Accordingly, the carrier should have applied the stop-loss reimbursement factor and paid 75% of the hospital's usual and customary charges, Rule 134.401(c)(6)(A)(iii)." The provider is seeking additional reimbursement in the amount of \$71,883.47.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier submitted a position statement that supports their reason for no additional reimbursement. "The Carrier maintains it's position that no additional reimbursement is due. The Provider admitted the Claimant for a 19-day surgical in patient stay with no preauthorization, and did not timely request concurrent review for length of stay until 09-03-2004, the day before discharge. The Provider billed \$106,566.25 for the stay. The Carrier reimbursed the Provider \$8,041.22, based on a five day inpatient stay, determined to be appropriate by the Carrier, plus additional reimbursement for the technical component of two MRI scans. Although the Provider finally requested preauthorization on 09-03-2004, the next day to last day of the admission, preauthorization cannot be issued retrospectively. Consequently, the remaining dates of service were properly denied for lack of preauthorization or concurrent review for length of stay."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)	
08/27/04-08/30/04	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."

The Carrier denied 14 days of the hospital stay for lack of preauthorization. The Provider did not refute this in their position statement, therefore only five days of inpatient will be reviewed per TWCC Rules and guidelines. The Respondent received the preauthorization request on 09/17/04 per the preauthorization request copy submitted in the Respondent dispute packet.

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 the patient had left lower extremity infection, with a rotational flap by plastic surgery and application of external fixator to the left lower extremity 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 plus carve-out methodology described in the same rule.

The provider did not submit any invoices indicating the amount billed for the implantables. Therefore, MDR cannot determine the charges of the implantables and no reimbursement is recommended for the implantables.

The carrier made reimbursement for the 5-day stay in the amount of \$8,041.22 per diem and cost for the MRI scans. The per diem rate for the inpatient stay is \$5,590.00 ($5 \times \$1,118.00$) plus \$2,451.22 for the MRI scans.

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:

Mic			

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.