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: Twelve Oaks Medical Center c/o Hollaway & Gumbert 3701 Kirby, Suite 1288 Houston, Texas 77098	MDR Tracking No.: M4-05-B446-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: State Office of Risk Management P O Box 13777 Austin, Texas 78711-3777 Box 45	Date of Injury: Employer's Name: State of Texas Insurance Carrier's No.: WC2229284

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted operative report, discharge summary, invoices and a position statement. The requestor indicates in their position statement that, "As stated above, our client does not agree with the position of the insurance carrier and is seeking assistance from Medical Dispute Resolution in order to resolve this issue."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier's position states; "In review of the dispute packet and additional documentation submitted by the Requestor for date of service 08/16/04 through 08/19/04 the Carrier found that the requestor has failed to meet its burden to prove additional reimbursement is warranted."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
08/16/04-08/19/04	Surgical Admission	I	$38.50

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 a posterior lumbar fusion L5-S1was performed, the patient was taken to the recovery room in satisfactory 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 plus carve-out methodology described in the same rule.

The carrier made reimbursement for the 3-day stay in the amount of $13,120.90.

The requestor billed $26,424.00 for the implantables.

The requestor submitted invoices indicating the cost for the implantables were $8,914.00.

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 $9,805.40 ($8,914.00 x 110%). Per diem for the 3-day stay is $3,354.00(3 x $1,118.000) + $9,805.40 for the implantables = $13,159.40 - $13,120.90 = $38.50 in additional reimbursement recommended.

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 $38.50. 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:

	Michael Bucklin	12/20/05
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.