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: Vista Medical Center Hospital 4301 Vista Pasadena, Texas 77504	MDR Tracking No.: M4-05-B505-01 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: Childrens Lighthouse Management, Inc. Insurance Carrier's No.: 99C0000322259

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted an operative report, discharge summary and invoices.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier submitted a position statement indicating: "This dispute involves this carrier's payment for the dates of service in dispute for which the requester charged $151,296.60 for a three day inpatient stay for services that were NOT unusually extensive or costly. This carrier reimbursed the requester for three days per diem ($1,118) per the TWCC Acute Care In-patient Fee Guideline. The requester was also reimbursed invoice cost plus 10% for the implants for the implants for which an invoice was provided. The carrier reimbursed the requester a fair and reasonable reimbursement plus cost plus 10% for the implants for which no invoice was provided."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
10/14/04-10/17/04	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 a posterior lumbar fusion from L4-L5 was performed, the patient remained stable throughout, even during the distraction phase. She was taken to recovery 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 plus carve-out methodology described in the same rule.

The carrier made reimbursement for the 3-day stay in the amount of $23,964.70 per the Table of Disputed Services.

The requestor billed $75,912.00 for the implantables.

The requestor submitted invoices indicating the cost for the implantables were $18,737.00.

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 $20,610.70 ($18,737.00 x 110%). Per diem amount is $3,354.00 + $22,610.70 for the implantables = $23,964.70, leaving no 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 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	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.