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) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes () No
Requestor Vista Hospital of Dallas 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M4-05-B628-01 TWCC No.: Injured Employee's Name:
Respondent's Liberty Mutual Fire Insurance Co. Rep. Box # 28	Date of Injury: Employer's Name: United Parcel Services Inc. Insurance Carrier's No.: 949745646

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-20-04	10-23-04	Inpatient Hospitalization	$82,353.62	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

"Payment is not in accordance with Acute Inpatient Stop Loss Fee Guideline."

Principle Documentation:

1. Requestor's position statement
2. EOB
3. UB-92

PART IV: RESPONDENT'S POSITION SUMMARY

"We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Acts and Rules…The bill has been reviewed per Rule 133.301 and the fee schedule guidelines, which allow for line item audits. Reductions may reflect fair and reasonable pricing, denial of personal items, non-compensable services, and or services not normally billed. Additional reductions, based on usual and customary charges in the same geographic area as the provider, have also been applied…Liberty Mutual does not believe that Vista Hospital of Dallas is due any further reimbursement."

Principle Documentation:

1. Respondent's position statement

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 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 documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." 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 total length of stay for this admission was 3 days (consisting of 3 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $3354.00 (3 times $1,118.00). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

Cost invoices support charges of $21,620.00. The Medical Review Division considers fair and reasonable reimbursement to be cost + 10% for implantables, resulting in a reimbursement for implantables of $23,782.00.

The charge for surgical admission of $3354.00 + $23,782.00 for implantables = $27,136.00.

The insurance carrier paid $60,676.06 for the inpatient hospitalization.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that additional reimbursement is not due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Elizabeth Pickle	May 26, 2006
Authorized Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

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.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____