



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 77098-3926	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">MDR Tracking No.:</td> <td>M4-05-B735-01</td> </tr> <tr> <td>Claim No.:</td> <td></td> </tr> <tr> <td>Injured Employee's Name:</td> <td></td> </tr> </table>	MDR Tracking No.:	M4-05-B735-01	Claim No.:		Injured Employee's Name:	
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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	<table style="width: 100%; border-collapse: collapse;"> <tr> <td>Date of Injury:</td> <td></td> </tr> <tr> <td>Employer's Name:</td> <td>Houston Society for the Prevention of Cruelty</td> </tr> <tr> <td>Insurance Carrier's No.:</td> <td>99D0000350987</td> </tr> </table>	Date of Injury:		Employer's Name:	Houston Society for the Prevention of Cruelty	Insurance Carrier's No.:	99D0000350987
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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, "As stated above, our client does not agree with the position of the insurance carrier and is seeking assistance from the Medical Dispute Resolution in order to resolve this issue."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier indicates in their position statement: "The following is the carrier's statement with respect to this dispute. This dispute involves this carrier's payment for date of service 8/23/2004 to 9/5/2004 for which the requester charged \$143,370.24; for services that were NOT unusually extensive or costly. Texas Mutual paid \$51,352.94 for a THIRTEEN day inpatient stay at a surgical per diem rate of (\$1,118) per the TWCC Acute Care In-Patient Fee Guideline. The requester was also reimbursed for CT scan of the abdomen and invoice plus 10% for the implants. The requester believes it is entitled to an additional \$56,174.74."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
08/23/04-09/05/04	Surgical Admission	I	\$56,174.74

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 the provider, it **does** appear that this particular admission involved “unusually extensive services.” The provider submitted an operative report indicating that a posterior and anterior fusion at L4-5 was performed and no complications were noted. The patient later developed a fever of 102 pertaining to a post-op infection and an ileus for which the patient remained in the hospital for an additional 8 day-stay. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the methodology described in the same rule.

Using the stop-loss methodology the total allowable WCRA is \$143,370.24.

The carrier has reimbursed the provider \$51,352.94.

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 an additional reimbursement for these services equal to \$56,174.74 (total allowable WCRA \$143,370.24 x 75% = \$107,527.68 - \$51,352.94 already paid = \$56,174.74.

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 \$56,174.74. 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:

Allen McDonald

01/31/06

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.