

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x)HCP ( )IE ( )IC	<b>Response Timely Filed?</b> (x)Yes ( )No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M5-04-0263-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Employers Ins. Co. of Wausau/Rep. Box : 28 P.O. Box 152800 Irving, TX 75015	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-23-02	10-29-02	Inpatient Hospitalization	\$45,593.19	\$5,679.12

## PART III: REQUESTOR'S POSITION SUMMARY

A position statement was not submitted. The Requestor's rationale listed on the Table of Disputed Services states, "F-Payment not in accordance with Acute In-Patient Stop Loss per Fee Guideline."

## PART IV: RESPONDENT'S POSITION SUMMARY

Position summary of October 8, 2003 states, "... Liberty Mutual does not believe that Vista Medical Center Hospital is due any further reimbursement..."

## 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** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 6 days. The operative report of 1-24-02 indicates the patient underwent "... 1. Bilateral laminectomy L4-L5, L5-S1, S1-S2, with foraminotomies L4, L5, S1 and S2 bilaterally. 2. Excision of portions of the spinous process of L4 complete of L5 and most of S1. 3. Exploration of fusion area. 4. Excision of fibrosis and pseudoarthrosis, S1-S2. 5. Sacroiliac graft. 6. Excision of herniated lumbar disk, L5-S1 from two portals. 7. Anterior fusion from a posterior approach using 13 x 24 BAK cages. 8. Lateral transverse fusion L5-S1, S1-S2. EBI bone stimulation of lateral transverse fusion L5-S1. 10. Posterolateral facet fusion, L5-S1 and into S1-S2. 11. Bilateral lateral instrumentation, S1-S2 with bilateral 1/4" rods and single cross link. 12. Fat graft, L4-S2. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding the charges for the implantables. The requestor billed \$82,332.00 for the implantables. The carrier paid \$18,252.30 for the implantables. The key issue is what amount would represent the usual and customary charges for these implantables in determining the total audited charges. The requestor did not provide the Commission with any documentation on the actual cost of implantables or how their charges were derived. Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%.

Based on a reimbursement of \$18,252.30, it appears that the carrier found that the cost for the implantables was \$16,596.00 (reimbursed amount divided by 110%). This amount multiplied by the average mark-up of 200% results in an audited charge for implantables equal to \$33,186.00.

The audited charges for this admission, excluding implantables, equals \$68,931.59. This amount plus the above calculated audited charges for the implantables equals \$102,117.59, the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to \$5,679.12 (\$76,588.19 - \$70,909.07 (amount paid by respondent)).

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 a reimbursement amount for these services equal to \$5,679.12.

**PART VI: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$5,679.12. 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 20-days of receipt of this Order.

Ordered by:

Roy Lewis

6-23-05

Authorized Signature

Typed Name

Date of Order

**PART VII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**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: \_\_\_\_\_