

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Road Pasadena, TX 77504	MDR Tracking No.: M5-04-1629-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Zenith Insurance Company BOX 47	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			
05/02/2003	05/05/2003	In-Patient Surgical Admission	\$53,167.33	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The carrier did not use the appropriate payment exception codes in denying or reducing the payment for this admission. The carrier also improperly disputed services based on medical necessity issues. The carrier has not provided any information to show that the hospital billed anything other than their usual and customary charges, which includes a price markup to cover various overhead costs. The carrier must pay the full admission based on 75% of the charges and owes the hospital an additional \$53,167.33.

PART IV: RESPONDENT'S POSITION SUMMARY

The carrier properly reimbursed the hospital a total of \$10,200.40 pursuant to the standard per diem plus carve-outs reimbursement method. The stop-loss method does not apply because the total audited charges are less than \$40,000 and the admission did not involve unusually costly or extensive services. The request for medical dispute resolution should be dismissed because the provider did not use the right form and did not comply with all the required rules. There are numerous examples of improper billing in this particular case, including mark-ups of over 473% for certain items. It is only through the use of unbundling services and changing in gross excess of the amount that should have been charged that the charges exceed \$40,000. In addition, a peer review report outlines the problems with the billing and results in a total audited charge of less than \$40,000.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Regarding the carrier's assertions that the request should be dismissed, the Division does not feel that dismissing this request is entirely appropriate and the merits of the case must be considered. While it is possible that the Division could dismiss this particular request due to the issues raised by the carrier, we believe that this approach would elevate form over substance.

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."

The first issue is whether or not the total audited charges exceed \$40,000. The carrier has provided very specific examples of potentially improper billing, duplicate billing, unbundling, and other problems with whether or not the charges truly are

“usual and customary.” The provider has not provided any sufficient information to explain their charges, other than a simple assertion that the charges are their usual and customary charges. Given the lack of information refuting the carrier’s position and restricting the reimbursement for those items questioned by the insurance carrier, it does not appear that the total audited charges exceed \$40,000.

In addition, it does **not** appear that this particular admission involved “unusually extensive services.” This admission involved an exploration of a previous fusion and a L4-5 lumbar arthrodesis. In discussions with our medical staff and reviewing the records, there is no information contained in the medical records to reflect that this procedure or the admission involved anything extensive. In addition, the report from Dr. Wilk states that: “The claimant entered the hospital with a minimal of comorbidities. She underwent an uncomplicated operative procedure with an uncomplicated post-operative course. There is no reason that this hospital bill should be unusually costly or extensive.”

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. One additional issue relates to the use of a finding by the insurance carrier that particular services were found not medically necessary based on a peer report. These findings would generally result in the selection of an Independent Review Organization to resolve the medical necessity question. However, in finding that the stop-loss method does not apply, the issue regarding these particular lines of billing becomes moot and it does not appear prudent to send this case to an IRO.

Therefore, 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 no additional reimbursement is 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:

Allen C. McDonald, Jr.

May 4, 2005

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 05/04/05. 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, MS35, 7551 Metro Center Dr., Suite 100, 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 in 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: _____