



MEDICAL DISPUTE RESOLUTION AMENDED FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor Spring Branch Medical Center c/o Hollaway & Gumbert 3701 Kirby Dr., Ste. 1288 Houston, TX 77098-3926	MDR Tracking No.: M5-05-3189-01
	TWCC No.:
	Injured Employee's Name:
Respondent Rep. Box # 15	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier failed to pay per TWCC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline and SOAH decision 453-04-3600.M4...Per TWCC Rule 134.401(c)(6)...claim pays @ 75% of total charges as charges exceed \$40,000.00 stop-loss threshold. IC further failed to audit according to TWCC Rule 134.401(c)(6)(A)(v). The total charges were \$80,561.83. The total payment of \$42,995.06 was made. The total amount in dispute is \$17,426.31.

Principle Documentation:

1. Requestor's position statement
2. UB-92s
3. EOB's
4. Itemized Statement
5. Medical Reports

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position statement was not submitted.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
11-13-03 to 11-22-03	Inpatient Hospitalization	1	\$6,310.06
TOTAL DUE			\$6,310.06

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

This AMENDED FINDINGS AND DECISION supersedes M4-05-1956-01 rendered in this Medical Payment Dispute involving the above requestor and respondent.

The Medical Review Division's Decision of 3-8-05 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 4-5-05.

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 insurance carrier gave preauthorization approval for three (3) inpatient days. The claimant remained in the hospital for 9 days. A review of the audit summaries indicate that the insurance carrier conducted a physician review and reduced some charges based upon lack of medical necessity. An IRO review was performed and found that “the patient’s hospitalization up until 11-21-03 was reasonable and related to her work-related injury and surgery performed”

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that the inpatient hospitalization was medically necessary from 11-13-03 to 11-21-03. The IRO concluded that inpatient hospitalization for 11-21-03 to 11-22-03 was not medically necessary.

On this basis, the total amount recommended for reimbursement does represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did prevail in the IRO decision. Consequently, the requestor is owed a refund of the paid IRO fee. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee.

After reviewing the documentation provided by both parties, it does appear that this particular admission involved “unusually extensive services.” Accordingly, the stop-loss method does 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 9 days (consisting of consisting of 1 day in an intense care unit and 8 days for surgical). Based upon IRO report the inpatient hospitalization was medical necessary until 11-21-03. A review of the itemized statement indicates that the requestor billed for \$4,006.82 for services rendered from 11-21-03 to 11-22-03. Therefore, this amount will be deducted from the total charges of \$80,561.83 = \$76,555.01.

In determining the appropriate reimbursement for implantables, it must be noted that the health care provider did not submit invoices. While this makes the determination more difficult, it would appear that implantables were clearly used during the surgical intervention and some amount is due to the health care provider. In this case, the requestor billed \$24,033.00 for the implantables.

Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%. We will apply this average mark-up to the charged amount in order to determine the amount to use in the decision. Based on a charge of \$24,033.00, it appears that the cost for these implantables was approximately \$12,016.50 (charged amount divided by 200%). Since the reimbursement for implantables is cost plus 10%, the amount due for the implantables would equal \$13,218.15.

The audited charges for this admission, excluding implantables, equals \$52,522.01 (\$76,555.01 minus \$24,033.00). This amount plus the above calculated audited charges for the implantables equals \$65,740.16, the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers’ compensation reimbursement amount equal to \$49,305.12.

The insurance carrier paid \$42,995.06 for inpatient hospitalization. The difference between amount paid and amount due = \$6,310.06.

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 \$6,310.06.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 413.011(a-d)
Rule 134.600 (h)(1)
Rule 134.401

PART VII: DIVISION AMENDED 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 \$6,310.06. 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.

Amended Order by:

November 18, 2005

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.