MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (X) No
Requestor Corpus Christi Medical Center c/o Hollaway & Gumbert 3701 Kirby Dr., Ste. 1288 Houston, TX 77098-3926	MDR Tracking No.: M4-05-0039-01 TWCC No.: Injured Employee's Name:
Respondent TX Public School WC Project Rep. Box # 21	Date of Injury: Employer's Name: Gregory Portland ISD Insurance Carrier's No.: 2112219

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
8-25-03	8-29-03	Inpatient Hospitalization	$25,027.78	$0.00

PART III: REQUESTOR'S 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).

PART IV: RESPONDENT'S POSITION SUMMARY

The hospital was reimbursed for the two days that were preauthorized at the surgical rate… The hospital billed the self-insured for a five day admission…was reimbursed $1,299.20 for CT scan and $8,053.15 for implants…The hospital has not shown that it is entitled to additional reimbursement. IN fact, most likely the hospital has been overcompensated because it appears the implants were paid at a rate greater than cost plus 10%. Cost plus 10% of the implants would be $2,273.78.

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

The carrier raises the issue of preauthorization in their response. The hospital obtained preauthorization for two days of service. Written preauthorization for the additional two days was not submitted. A review of the EOB does not support that preauthorization was raised prior to request for medical dispute resolution. Services were denied based upon "F" and "D".

Services denied with "D" were not duplicate; therefore, will be reviewed per Rule 134.401.

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."

A review of the discharge summary did not reveal any "unusually extensive services, no complications and claimant did well.

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 4 days (consisting of 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $4472.00(4 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

Synthes invoice $784.82
Synthes invoice $1282.26

Total of invoice $2067.08 + 10% = $2273.78.

Total of invoice $2273.78 + CT scan $1,299.20 and surgery per diem $4472.00 = $8044.98.

The insurance carrier paid $11,588.35 for 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 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:

	Elizabeth Pickle	04/04/05
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 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: _____