MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address AHC on behalf of Arlington Memorial Hospital 10002 Battleview Parkway Manassas, Virginia 20109	MDR Tracking No.: M4-05-0142-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address The Charter Oak Fire Insurance Company 1501 S MoPac Expressway, Suite A-320 Austin, Texas 78746-7541 Box 05	Date of Injury: Employer's Name: Household International, Inc. Insurance Carrier's No.: 039CBD978212E

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/25/03	09/28/03	Surgical Admission	$25,020.45	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

"TWCC laws state that any claim greater than $40,000.00 must be paid at stop loss. Stop loss payment is 75percent of the total charges. The Patient's claim met stop loss, with total charges of $158,417.86. The Stop loss payment that should have been paid to my client is $115,417.86. Carrier paid $33,527.42, under the rules and regulations of the commission, this payment is incorrect. Carrier still owes an additional payment in the amount of $81,890.44."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely.

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 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 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 operative report indicates that a posterior fusion L5-S1 was performed. The operative report also indicates that the patient tolerated the procedure well and was transferred to the recovery room in stable condition. No complications were noted in the operative report.

The carrier made reimbursement based on per diem and carve out of the implantables (3 day stay) bringing the total amount of reimbursement to $33,527.42. The carrier indicates per a letter dated September 28, 2004; "This bill was paid at perdiem rate for a 3 day (3x $1,118.00) stay plus implants. The provider supplied invoices for the implants showing their cost, which was reimbursed at their cost plus 10%. The provider was billing for $118,960.53 for implants yet the cost for all items was only $27,190.30. We paid $29,909.33 for those implants. We also paid $264.09 for blood products." The requestor did not submit an invoice to determine reimbursement for the implantables; therefore MDR cannot determine the cost of the implants.

Therefore, 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 not entitled to an additional reimbursement.

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.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Michael Bucklin	06/07/05

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, 7551 Metro Center Drive, 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 and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____