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 HEALTHSOUTH Medical Center 2124 Research Row Dallas, Texas 75235	MDR Tracking No.: M4-05-0283-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Royal Indemnity Company P O Box 9008 Addison, Texas 75001-9008 Box 11	Date of Injury: Employer's Name: FYI, Inc. Insurance Carrier's No.: 290026046900

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/09/03	**10/13/03**	**Surgical Admission**	**$40,379.81**	**$726.40**

PART III: REQUESTOR'S POSITION SUMMARY

No position statement found in the case file.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not respond to the dispute.

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."

Carrier denied services as medically unnecessary with the denial code of "U". Carrier cannot retrospectively deny services that have been preauthorized per TWCC rule 133.301(a). The provider submitted evidence that they received preauthorization per a hard copy approval by the carrier dated 09/23/03. Therefore, this admission will be reviewed per the Acute Care Inpatient Hospital Fee Guideline.

After reviewing the information provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." The operative report indicates that this was a posterior lumbar fusion. The operative report also indicates the patient tolerated the procedure without difficulty or complications. 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 carrier made no reimbursement for the 5-day stay. Therefore, based on a per diem reimbursement (5 day-stay x $1,118.00 = $5,590.00).

The carrier made a total reimbursement in the amount of $16,919.60 per a telephone conversation with the Requestor's representative on the week of June 27th, 2005.

The requestor submitted an invoice indicating the cost for the implantables was $10,959.50.

Therefore, reimbursement per diem is $5,590.00 ($5 x $1,118.00) and reimbursement for the implantables at cost plus ten percent is $12,055.45 ($10,959.50 x 10%). Per diem for the 5-day stay is $5,590.00 + $12,055.45 = $17,645.45 - $16,919.60 already paid = $726.40 in recommended additional reimbursement.

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 entitled to 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** entitled to reimbursement in the amount of $726.40. 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 this Order.

Ordered by:

	Michael Bucklin	08/02/05
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 and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____