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 Harris Methodist Hospital 3255 Pioneer Parkway Arlington, TX 76010-5312	MDR Tracking No.: M4-05-0425-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address AMERICAN PROTECTION INSURANCE CO PO BOX 162443 WESTLAKE STATION AUSTIN TX 787160000 Austin Commission Representative Box 42	Date of Injury: Employer's Name: Summit Tile & Granite Tile Art Insurance Carrier's No.: 900000019

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/25/03	12/03/03	Surgical Admission	$47,824.16	$1,342.00

PART III: REQUESTOR'S POSITION SUMMARY

Stop-Loss, ER Admit not paid at fair and reasonable.

PART IV: RESPONDENT'S POSITION SUMMARY

Review of the available documentation fails to support the emergency department care and the extended inpatient stay as reasonable or necessary to treat the occupation injury of ___.

Review of the available clinical documentation fails to support the need for emergency department care. It is notes that the patient reported having run out of narcotic analgesics and sneezed, causing increased pain. Review of the emergency department physician's examination fails to document any increase in neurological or muscle strength deficits as compared to Dr. Wilson's examination performed on 11/13/03. The patient was seen in the emergency department early in the morning. The intensity of service provided by emergency department care is not supported by the physical examination findings.

The need for inpatient hospital admission on 11/26/03 would have been reasonable and appropriate to provide the previously authorized surgical intervention. The length of stay from 11/26/03 to 11/29/03 would be reasonable and appropriate to address Mr. ___'s surgical and immediate post-operative care needs. These needs would be inclusive of pain management, intravenous fluid and medication administration, wound care, initial physical therapy, and hemodynamic monitoring.

There is a lack of objective, quantifiable documentation to support the need for inpatient care after 11/29/03. The intensity of service provided by inpatient hospitalization was not support by the documentation.

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 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 emergency room admission was disallowed as the surgery had been preauthorized for the surgery for a 3 day time frame of 11/24/03-1/05/04; and the surgery was performed on 11/26/03. No documentation was provided by the requestor that provided information for the necessity of the ER admission instead of a normal surgical admission; and therefore, a 3 day inpatient stay for this pre-authorized surgery was allowed and not the four days plus ER charges as billed by the requestor.

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 3 days (consisting of 3 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $3,354 (3 times $1,118). Requestor billed for 8 days or $4200.00. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

Documentation was provided for $9,033.00 for implantables. Cost plus 10% = $9,936.30.

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 $1,342.00.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $1,342.00. 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 receipt of this Order.

Ordered by:

	Gail A. Anderson	03-10-05
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: _____