MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor HCA Healthcare 6000 NW Parkway, Ste. 124 San Antonio, TX 78249	MDR Tracking No.: M4-05-0632-01 TWCC No.: Injured Employee's Name:
Respondent TML Intergovernmental Risk Pool Rep. Box # 19	Date of Injury: Employer's Name: City of Laredo Insurance Carrier's No.: T070200073912

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
3-30-04	4-8-04	Inpatient Hospitalization	$43,487.04	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Per TWCC contract total charges exceed $40,000 are reimbursed @ 75%. Audited charges are patient convenience items and non-covered charges.

PART IV: RESPONDENT'S POSITION SUMMARY

Corvel audit report indicates, "Southwest Texas Methodist Hospital was issued a precertification for surgery to include a three to five day length of stay. Corvel has recommended $1118.00 for five days, the additional four days were denied as 'A –Preauthorization required but not requested.' Therefore, since five days were preauthorized, technically, this would not be a true stop loss, as the total amount that should be audited would have been $15,721.10, plus the implant charges of $55,212.00…The total amount to be reimbursed would be $20,577.70."

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

A issue: 4 dates of service were denied based upon "A – Preauthorization required/not requested." The requestor did not support position that preauthorization was obtained; therefore, reimbursement for the additional four days is not recommended.

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 operative report indicates that, "Total lamincetomy of L4, total laminectomy of L5, bilateral discectomies at L4-5 and L5-S1, laminectomy for decompression of stenosis and the nerve roots at L4, 5 and S1 bilaterally, posterior lumbar interbody fusion L4-5 with two 15-mm Synthes spacers at L5-S1 with two 13-mm Synthes spacers, posterolateral fusion L4-5 and L5-S1 with VITOSS foam and autogenous iliac crest bone and local bone. Reconstruction of the right posterior iliac crest with BITOSS and internal fixation using the two pedicle screws."

The discharge summary indicated that, "He was admitted and underwent a two-level L4-5 and L5-S1 laminectomy, discectomy, and fusion. Despite his large size and his obesity, we were able to do the two level surgery uneventfully and with good success."

The total length of stay for this admission was 9 days; however, only 5 days were preauthorized consisting of 5 days for surgical. Accordingly, the standard per diem amount due for this admission is equal to $5590.00 (5 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

The actual cost for the implants per invoices was $18,707.00 + 10% = $20,577.70.

TOTAL of Invoices and Per Diem/ Surgery $20,577.70+ $5590.00 = $26,167.70

The insurance carrier audited the bill and paid $26,167.70 for the 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.

Decision by:

	Elizabeth Pickle	April 28, 2005
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: _____