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 Advanced Practice, Inc. on Behalf of Baylor All Saints Medical Center 17101 Preston Road, Suite 180-S Dallas, Texas 75248	MDR Tracking No.: M4-05-0652-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address WINN DIXIE LOUISIANA INC C/O SEDGWICK CLMS MANAGEMT SER ATTN: NORMA CHESSER JACKSONVILLE FL 322414787 Box 42	Date of Injury: Employer's Name: Insurance Carrier's No.: 00009433

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09-23-04	09-27-04	Surgical Admission	$26,715.74	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

On behalf of Baylor All Saints Medical Center, we have reviewed the claims and payment for the above admission. Our findings reveal this claim has not been paid according to the hospital fee guideline published by the Texas Workers Compensation Commission (TWCC). The guideline states any hospital admission with billed charges above $40,000…Shall be reimbursed per the stoploss methodology using a stoploss reimbursement factor of 75%. It appears this claim meets the stoploss requirement; however, reimbursement does not represent this methodology. Please reconsider payment for this admission per the above TWCC guidelines.

PART IV: RESPONDENT'S POSITION SUMMARY

To invoke the Stop-Loss reimbursement provisions, the Requestor must meet two criteria: (1) the audited charges must exceed $40,000, the minimum stop-loss threshold, and (2) the services made the basis of the charges must be unusually extensive/costly. Nowhere in any of the submitted documentation does the Requestor indicate the services were unusually extensive or costly. Nothing in the documentation describes complications of any nature; nothing shows the procedure was anything but routine.

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 documentation provided by the provider, primary procedure of left transforaminal lateral interbody fusion with L5-S1 with Devex cage, 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 four (4) days (consisting of 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $4,472.00 (4 times $1,118.00). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

An invoice from Community Blood Center/Community Tissue Services in the amount of $1,675.00 X 110% = $1,842.50
An invoice from DePuy Acro Med in the amount of $9,565.00 X 110% = $10,521,50

The carrier has reimbursed the provider $26,328.40.

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.

Ordered by:

		04-05-05
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: _____