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
Texas Orthopedic Hospital
C/O Hollaway & Gumbert
3701 Kirby Drive, Ste. 1288
Houston, TX 77098-3926

MDR Tracking No.: M4-05-0665-01

TWCC No.:

Injured Employee's Name:

Respondent's Name and Address
CONTINENTAL CASUALTY CO
BURNS ANDERSON JURY & BRENNER
PO BOX 26300
AUSTIN TX 78755-0300

Austin Commission Representative
Box 47

Date of Injury:

Employer's Name:

Insurance Carrier's No.: 900000070

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
9/23/03	**9/27/03**	**Inpatient Hospitalization**	**$26,402.51**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Texas Orthopedic Hospital's request for medical dispute resolution pertains to medical services and treatment provided to the injured employee, ___, during the period September 23, 2003 through September 27, 2003. To date, a total of $7,204.26 has been paid in connection with this claim. It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines of the Texas Workers' Compensation Commission ("TWCC"). Specifically on the dates September 23, 2003 through September 27, 2003, ___ received treatment at our client's facility relating to spinal surgery. Because Ms. ___ admission was inpatient, this claim would be reimbursed pursuant to TWCC Rule 134.401 entitled "Acute Care Inpatient Hospital Fee Guideline." According to Rule 134.401(c)(6), TWCC, this claim would then be reimbursed at the stop-loss rate of 75% as the total audited charges exceed the minimum stop-loss threshold of $40,000.00.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier paid Provider a total of $10,651.26 under the standard per diem reimbursement method of ACIHFG. This amount represents reimbursement of $1,118 for each of the four days plus reimbursement of implants at cost plus ten percent ($6,104.26) and reimbursement for blood at fair and reasonable ($75.00).

Provider asserts that it is entitled to reimbursement under the stop-loss reimbursement method. Carrier asserts that reimbursement should be pursuant to the standard per diem model.

The stop-loss reimbursement method is an exception to the rule that was designed to be used in limited and unusual circumstances where the standard per diem reimbursement methodology may not provide adequate reimbursement to the hospital because of unusually costly or extensive services rendered during treatment of the injured worker.

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."

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 4 days (consisting of 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $4,472 (4 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

Item	Amount
2 Screw SYN 418025 CNC 6.5	38.30
2 Washer SYN 41999 TTN 13	31.04
2 BNE Pwdr 15C 120120	530.00
1 Clip Hemoclip 523800 M	81.34
5 SYN SP Nut 11MM2-4980	157.60
2 SYN SP Rodhard 75 4981	240.56
2 SYN SP SCR Side 7X35	746.90
3 SYN SP SCR Side 7X40	1,120.35
5 SYN SP Trans 498011	400.10
1 BNE FEM X SEC 34M 10045	502.00

Total of Implantables: $3,848.19
Cost plus 10% = $4,233.01

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. Insurance carrier paid $10,651.26.

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.

Findings and Decision by:

______________________	______________________	3-18-05
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 in the Austin Representative's box.

Signature of Insurance Carrier: ____________________________________ Date: ____________________