MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Tenet Healthcare/RHD Medical Center 2401 Internet Blvd., Suite 110 Frisco, Texas 75034	MDR Tracking No.: M4-05-0763-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Home Assurance Company P O Box 13367 Capitol Station Austin, Texas 78711 Box 19	Date of Injury: Employer's Name: AMR Corporation Insurance Carrier's No.: YBUC 23053

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/25/04	**02/28/04**	**Hospital Admission**	**$28,210.88**	**$1,562.00**

PART III: REQUESTOR'S POSITION SUMMARY

"On behalf of Provider, we have reviewed the claim and payment for the above hospital admission. Our findings reveal this claim has not been paid according to the hospital fee guideline published by the Texas Workers Compensation Commission (TWCC). This claim in the amount of $65,982.94 is an inpatient surgical claim in which charges exceed $40,000, the stoploss threshold amount, however payment is not based on this methodology and we request you to review this for Medical Dispute Resolution as a Fee Dispute."

PART IV: RESPONDENT'S POSITION SUMMARY

"Because a hospital can arbitrarily and unilaterally increase its billed charges to any level it chooses, so long as it charges the same price to all payors, $40,000 in billed charges is not sufficient to indicate a need to pay more than the per diem method plus additional reimbursement. The stop-loss method is justified only when a patient requires services that are more extensive and costly that usually required by a patient with that diagnosis, treatment and length of stay. To meet the criterion the hospital must identify unusual characteristics of the patient or the treatments provided that generated unusual costs for the hospital. The unusual costs should not be for costs covered by revenue codes in 134.401(c)(4)."

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 information 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 methodology described in the same rule. The procedure code identifies that this was a lumbar fusion. The requestor did not submit an operative report.

The carrier made reimbursement based on per diem for the 2-day stay $2,236.00(2 x $1,118 = $2,236.00 per diem). The carrier also reimbursed the requestor an additional amount of $4,609.00 for the implantables, the provider billed $9,291.80. The provider submitted invoices totaling $2,805.00 in billed amount, so using the billed amount at cost plus ten percent $3,085.50 ($2,805.00 x 110% =

$3,085.50). The total amount of per diem and cost plus ten percent is $8,407.00 and the carrier reimbursed the provider $6,845.00, leaving $1,562.00 in 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 additional reimbursement in the amount of $1,562.00. 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 this Order.

Ordered by:

	Michael Bucklin	05/10/05
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: _____