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. Frisco, Texas 75034	MDR Tracking No.: M4-05-0767-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company 6210 East Highway 290 Austin, Texas 78723-1098 Box 54	Date of Injury: Employer's Name: Dallas Youth Services Corps, Inc. Insurance Carrier's No.: 99A0000264288

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/13/03	10/13/03	Surgical Admission	$58,154.69	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

"Please review claim at Stop Loss per TWCC Rule 134.401. Audited charges are those charges which remain after a bill review by the insurance carrier has been preformed. Those charges which may be deducted are personal items."

PART IV: RESPONDENT'S POSITION SUMMARY

"This dispute involves this carrier's payment for dates of service in dispute for which the requester charged $102,711.45 for seven days inpatient stay for services that were NOT unusually extensive or costly. This carrier reimbursed the requester the preauthorized seven days surgical per diem ($1,118) and one day ICU based on the TWCC Acute Care In-Patient Fee Guideline. This carrier reimbursed the requester a fair and reasonable reimbursement plus 10% for implants and fair and reasonable reimbursement (i.e., 62% of the amount billed)."

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."

The provider did not submit an operative report, however the requester did submit a peer review that indicates that there were no complications and/or extensive services during the procedure. The peer review suggests there were some complications postoperatively for the evaluation of the patient's abdomen and retroperitoneal space which required CT scan and x-rays. The review indicates nothing was found that required any more medical treatment than watchful waiting. Also, the Requestor did not submit an invoice for the implantables.

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 plus carve-out methodology described in the same rule.

The carrier made reimbursement based on per diem and carve out of the implantables (7 day stay and 1 day ICU in the amount of $9,386.00 and $8,076.78 cost plus ten percent for the implantables, $992.72 for the CT ct-scan, $423.40 for blood processing bringing the total amount of reimbursement to $18,878.90)

Therefore, 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 not entitled to an 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 not entitled to additional reimbursement.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Michael Bucklin	04/19/05

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, 7551 Metro Center Drive, Suite 100, 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: _____