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 HCA Clear Lake Regional Medical Center 3701 Kirby Drive, Ste. 1288 Houston, TX 77098-3926	MDR Tracking No.: M4-05-0778-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address AMERICAN HOME ASSURANCE CO PO BOX 13367 CAPITOL STATION AUSTIN TX 78711-0000 Austin Commission Representative Box 21	Date of Injury: Employer's Name: Insurance Carrier's No.: 900000017

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/02/03	**10/03/03**	**Surgical Admission**	**$30,162.54**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Based upon review by the insurance carrier, AR Claims Management, Inc. ("AR Claims"), and its audit department, alleges that the aforementioned claim has been properly paid. On the contrary, specifically, per Rule 134.401 (c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ("SLRF") of 75%. Per Rule 134.401 (c)(6)(A)(v), the only charges that may be deducted from the total bill are those for personal items (i.e., television, telephone) and those not related to the compensable injury. Moreover, Rule 134.401 (c)(6)(A)(v) states what the carrier can deduct in the audit. The carrier should not confuse the carve-out items identified in section (c) (4) as items that can be deducted in an audit or paid separately. Therefore, reimbursement for the entire admission including charges for items in (c)(4) is calculated by the stop-loss reimbursement amount of 75% times the total audited charges. The implantables were a medically necessary part of the surgery performed. Therefore, the fees paid by AR Claims Management, Inc. do not conform to the reimbursement section of Rule 134.401. Therefore, pursuant to the TWCC fee guidelines, the claim pertaining to dates of services: 10/02/03 – 10/03/03, is to be paid as follows:

Total Billable Charges:	$43,446.26
SLRF (75%)	$10,861.57
Total Allowable:	$32,584.70
Amount Paid:	$ 2,422.16
Balance Due:	$30,162.54

PART IV: RESPONDENT'S POSITION SUMMARY

I am filing the TWCC-60 Form on behalf of the above-referenced insurance carrier in response to the Requestor's dispute for fee reimbursement for date of service of 10/02/03 through 10/03/03. As a result, no further reimbursement was recommended towards the amount in dispute of $30,162.54.

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 1 days (consisting of 1 day for surgical). Accordingly, the standard per diem amount due for this admission is equal to $1,118 (1 times $1,118). Requestor billed $420.00. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

The documentation provided an invoice in the amount of $1,537.49. Cost plus 10% = $1,691.24.

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 $2,422.16.

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:

		03-17-05
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: _____