MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (X) No
Requestor Tenet Healthcare/RHD Medical Center 2401 Internet Blvd., #110 Frisco, TX 75034	MDR Tracking No.: M4-05-0851-01 TWCC No.: Injured Employee's Name:
Respondent Texas Builders Insurance Co. Rep. Box # 01	Date of Injury: Employer's Name: Countrywide Financial Corp Insurance Carrier's No.: 95801355903205

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4-1-04	4-2-04	Inpatient Hospitalization	$33,030.17	$5,160.62

PART III: REQUESTOR'S POSITION SUMMARY

Stoploss - Pays 75% billed charges.

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement was not submitted.

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 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $1118.00 (1 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

Cost invoices to support additional reimbursement per Rule 134.401(c)(4) were not submitted.

In determining the appropriate reimbursement for implantables, it must be noted that the health care provider did not submit invoices to the Commission. While this makes the determination more difficult, it would appear that implantables were clearly used during the surgical intervention and some amount is due to the health care provider. In this case, the requestor billed $9,383.05 for the implantables.

Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%. Since neither the requestor nor the respondent provided any documentation regarding the cost of the implantables, we will apply this average mark-up to the charged amount in order to determine the amount to use in the decision. Based on a charge of $9,383.05, it appears that the cost for these implantables was approximately $4,691.52 (charged amount divided by 200%). Since the reimbursement for implantables is cost plus 10%, the amount due for the implantables would equal $5,160.62.

Surgery per diem + implantables = $6,278.62.

The insurance carrier paid $1118.00 for the inpatient hospitalization. The difference between amount paid and amount due = $5,160.62.

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 entitled to a reimbursement amount for these services equal to $5,160.62.

PART VI: COMMISSION DECISION AND ORDER

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 $5,160.62. 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 receipt of this Order.

Ordered by:

Authorized Signature	Elizabeth Pickle, RHIA	June 20, 2005
	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: _____