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., #110
Frisco, TX 75034

MDR Tracking No.: M4-05-1260-01

TWCC No.:

Injured Employee's Name:

Respondent's Name and Address
Zurich American Ins. Co./Rep. Box #: 19
C/o Flahive, Ogden & Latson
P.O. Box 13367
Austin, TX 78711-3367

Date of Injury:

Employer's Name: HB Zachry Construction Corp.

Insurance Carrier's No.: YBUC 44175

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-27-03	11-7-03	Inpatient Hospitalization	$103,454.33	$1,287.00

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of October 13, 2004 states, "…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 $154,354.34 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

Position summary of November 8, 2004 states, "…It is the carrier's position they have correctly reimbursed the provider using the per diem methodology and no additional reimbursement should be made."

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." The UB-92 lists the "Prin Diag 722.10"; lumbar disc displacement and the "Prin. Procedure 81.06"; lumbar anterior fusion. 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 11 days (consisting of 11 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $12,298.00 (11 times $1,118). The Respondent paid $11,011.00 for Rev. Code 110 (billed amount) and $1,287.00 for Rev. Code 250. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The Requestor did not submit any medical documentation that the surgery involved unusually extensive services. The Requestor submitted invoices for the implantables however, medical documentation was not submitted.

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 $1,287.00 ($12,298.00 - $11,011.00).

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 $1,287.00. 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 receipt of this Order.

Findings and Decision by:

______________	Roy Lewis	5-17-05
Authorized Signature	Typed Name	Date of Decision

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 in the Austin Representative's box.

Signature of Insurance Carrier: ________________________________ Date: ____________________