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 Covenant Medical Center P.O. Box 1866 Fort Worth, TX 76101	MDR Tracking No.: M4-05-1280-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Ins. Co./Rep. Box #: 54 P.O. Box 12029 Austin, Texas 78711-2029	Date of Injury: Employer's Name: Texas Boll Weevil Eradication Insurance Carrier's No.: Texas Mutual Ins. Co.

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-28-03	12-4-03	Inpatient Hospitalization	$66,854.03	$66,854.03

PART III: REQUESTOR'S POSITION SUMMARY

Position summary was not submitted. However, the Respondent's rationale on the Table of Disputed Services states, "should have been paid at stoploss the entire stay had extenuating circumstances".

PART IV: RESPONDENT'S POSITION SUMMARY

Position summary of October 27, 2004 states, "… This dispute involves this carrier's stop loss payment for dates of service in dispute for which the requester charged $250,300.61. This carrier reviewed the charges in dispute, denied unbundled and convenience charges and reimbursed requester 75% of charges billed after audit. This carrier also reimbursed the requester a fair and reasonable reimbursement for the MDRI. No cost information has been provided for the Ambisone, there no reimbursement for the Ambisone has been 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 the Requestor, it **does** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 37 days based upon a puncture wound of left hand. During the stay the patient developed a fungal infection of the left hand and was also "seen for management of diabetes which the patient had suffered for approximately seven years prior to his admission". Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

The Requestor billed $430,103.15 (UB-92). The Respondent reimbursed $255,718.23. The Requestor's Table of Disputed Services is seeking reimbursement for Rev. Codes 250, 600 and 610 (75% of $310,393.35). The Respondent reimbursed $165,940.940.98 leaving a disputed amount of $66,854.03. Due to the medical information provided, the admission involved "unusually extensive services". Therefore, the stop-loss reimbursement factor of (75%) results in a workers' compensation reimbursement amount equal to $66,854.03 ($232,795.01 - $165,940.98).

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 $66,854.03.

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 $66,854.03. 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:

	Allen McDonald	5-19-05
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: ________________________