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 Texas Orthopedic Hospital C/o Hollaway & Gumbert 3701 Kirby Dr., Suite 1288 Houston, TX 77098-3926	MDR Tracking No.: M4-05-1537-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address ACIG Ins. Co., Rep. Box #: 47 C/o Burns Anderson Jury & Brenner P.O. Box 26300 Austin, TX 78755-0300	Date of Injury: Employer's Name: Young Brothers Inc. Contractors Insurance Carrier's No.: 643403A8199691

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	10-31-03	Inpatient Hospitalization	$26,898.69	$26,898.69

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of November 19, 2004 states, "… It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines… Specifically on the dates October 28, 2003 through October 31, 2003… admission was inpatient, this claim would be reimbursed pursuant to TWCC Rule 134.401… this claim would then be reimbursed at the stop-loss rate of 75% as the total audited charges exceed the minimum stop-loss threshold of $40,000…".

PART IV: RESPONDENT'S POSITION SUMMARY

A position summary 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** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 3 days based upon "1. Treatment of left tibial nonunion with autogenous iliac crest bone graft marrow. 2. Application of Ilizarov external fixator, left lower extremity. 3. Partial excision and craterization of left fibula. 4. Osteoplasty lengthening, left tibia. 5. Removal of EBI external fixator, unilateral fixator, left lower extremity. 6. Irrigation and debridement of skin, subcutaneous tissue, muscle and bone of pin sites, left lower extremity." Accordingly, the stop-loss method does apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The Requestor billed $48,079.32. The Respondent reimbursed $9,160.80. 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 $26,898.69 ($36,056.49- $9,160.80).

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 $26,898.69

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 $26,898.69. 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	5-20-05
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, 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: _____