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 Spring Branch Medical Center C/o Hollaway & Gumbert 3701 Kirby Dr., Suite 1288 Houston, TX 77098-3926	MDR Tracking No.: M4-05-1582-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Atlantic Mutual Ins. Co. /Rep. Box #: 19 C/o Flahive, Ogden & Latson 505 West 12th Street Austin, TX 78701	Date of Injury: Employer's Name: Parker Uniforms Inc. Insurance Carrier's No.: 21916107

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-30-03	11-2-03	Inpatient Hospitalization	$26,697.98	$26,697.98

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of November 19, 2004 states, "… a total of $13,778.80 has been paid… It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guideline of the Texas Workers' Compensation Commission… According to Rule 134.401(c)(6)… 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

Position summary of November 18, 2004 states, "… In the immediate case the provider has failed to submit any claim-specific substantive explanation with its request for reconsideration… Accordingly, that the request was not complete and fails to satisfy the perquisite for medical dispute resolution… This is a medical fee dispute arising from an inpatient hospital surgical admission… The Requestor asserts it is entitled to reimbursement in the amount of $40,476.78, which is 75% of the total charges… Using the per diem method, this three-day surgical admission qualified for $3354.00 ($1,118 * 3 days) in reimbursement…".

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Rule 133.304(k), Medical Payments and Denials, allows the Requestor to submit the bill to the insurance carrier for reconsideration when dissatisfied with the insurance carrier's final action. The Requestor submitted a seven page fax request for reconsideration to the insurance carrier and was received by the insurance carrier for reconsideration.

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 "Lumbar radicular syndrome status post lumbar decompression at L5-S1 six months ago with recurrent disk herniation at L5-S1 and instability of L5-S1.". The patient underwent a "1. Redo subtotal laminectomy, L5-S1. 2. Facetectomy, left side at L5-S1. 3. Foraminotomies, bilateral diskectomy L5-S1. 4. Transforaminal interbody fusion using PEEK cage with autogenous iliac crest bone graft. 5. Posterolateral fusion, L5 to the sacrum

using the autogenous iliac crest bone graft and allograft with segmental spinal fixation using the Spinal Concept Pedicle Screw and Rod System. 6. Harvesting left iliac crest bone graft for spinal fusion. 7. Reconstruction of left iliac crest with cancellous allograft. 8. Segmental spinal fixation performed under fluoroscopic control.". Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

The Requestor billed $53,969.04. The Respondent reimbursed $13,778.80. 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 $3,374.53 ($40,476.78 - $13,778.80).

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 $26,697.98.

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 $26,697.98. 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	5-23-05
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: _____