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 Harris Methodist HEB 3255 W. Pioneer Parkway Arlington, Texas 76013	MDR Tracking No.: M4-05-1585-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance Company P O Box 40460 Houston, Texas 77240-0460 Box 28	Date of Injury: Employer's Name: United Parcel, Inc. Insurance Carrier's No.: 949517333

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
07/02/04	**07/13/03**	**Surgical Admission**	**$33,406.91**	**$654.60**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position statement.

PART IV: RESPONDENT'S POSITION SUMMARY

"We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Acts and Rules."

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 additional 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 information provided by the provider, 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 provider did not submit an operative report indicating what procedure was done.

The EOB indicates that the services were only preauthorized for 5 days. The additional 6 days were not preauthorized. The requestor did not refute this in their position statement.

The carrier denied the implants with the denial of F-the charge for this procedure exceeds the Health Facility fee schedule assigned by the Texas Workers Compensation Commission and U-This service was not authorized.

In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding the charges for the implantables. The requestor billed $5,498.00 for the implantables. The carrier paid $545.50 for the implantables based on a cost plus 10% approach. The key issue is what amount would represent the usual and customary charges for these implantables in determining the total audited charges. The requestor did not provide the Commission with any documentation on the actual cost of implantables or how their charges were derived.

Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%.

Since the requestor did not present any documentation supporting their cost or charge, we will apply this average mark-up to the cost amount derived from the carrier's payment in order to determine the amount to use in the total audited charges. Based on a reimbursement of $545.50, it appears that the carrier found that the cost for the implantables was $600.05 (reimbursed amount divided by 110%). This amount multiplied by the average mark-up of 200% results in an audited charge for implantables equal to $1,200.10.

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 an additional reimbursement amount for the implantables, in the amount of $654.60.

Therefore, 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 not entitled to additional reimbursement of $654.60.

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 $654.60. 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 this Order.

Ordered by:

	Michael Bucklin	05/10/05
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: _____