MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor Medical Center of Plano 10030 N. MacArthur Blvd., Ste. 100 Irving, TX 75063	MDR Tracking No.: M4-05-1713-01 TWCC No.: Injured Employee's Name:
Respondent Healthsouth Corp. Rep. Box 15	Date of Injury: Employer's Name: Healthsouth Corp. Insurance Carrier's No.: 27701355884846

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	**11-1-03**	**Inpatient Hospitalization**	**$129,797.24**	**$2,207.05**

PART III: REQUESTOR'S POSITION SUMMARY

Per TWCC Fee Guidelines this claim qualifies for stop loss methodology payment. Charges exceed the $40,000 threshold, so entire claim should be paid at 75% of charges. Per San Antonio ISD vs. TWCC and Metropolitan Methodist Hospital (Docket No. 453-03-1233.M4). implants should not be removed on stop loss claims.

PART IV: RESPONDENT'S POSITION SUMMARY

AccuMed, our medical bill vendor, had originally reviewed the bill on 1-15-2004 and approved $40,042.19 which we paid on 01-27-2004. A hospital bill review was conducted and completed on 1-14-2004 which indicated an additional $34,053.80 was due as a result of the nurse's audit. Unfortunately the two bills crossed and the $34,053.80 was not paid. I currently have the bill for $34,053.80 in the process to be paid with interest. A total of $74,758.37 will have been paid plus the interest due of approximately $1,281.28.

The hospital bill review identified an overstatement of the implant of $151,694.20.

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 5 days based upon carrier's response that assessed that this was a stop loss inpatient hospitalization. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

The requestor billed $226,452.57 for the hospitalization. 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 $185,748.00 for the implantables. The carrier paid $34,053.80 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 reimbursement of $34,053.80, it appears that the carrier found that the cost for the implantables was $30,958.00. This amount multiplied by the average mark-up of 200% results in an audited charge for implantables equal to $61,916.00.

The audited charges for this admission, excluding implantables, equals $40,704.57. This amount plus the above calculated audited charges for the implantables equals $102,620.57 the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to $76,965.42.

The insurance carrier audited the bill and paid $74,758.37 for the inpatient hospitalization. The difference between amount paid and amount due = $2,207.05.

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 $2,207.05.

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 $2,207.05. 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:

	Elizabeth Pickle, RHIA	June 13, 2005
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: _____