

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 Leon E. Pegg, Attorney for Holloway & Gumbert on behalf of Spring Branch Medical Center 3701 Kirby Drive, Ste. 1288 Houston, TX 77098		MDR Tracking No.: M4-05-1927-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address Box 19 Insurance Company of the State of PA Flahive, Ogden & Latson Post Office Drawer 13367 Austin, TX 78711		Date of Injury:	
		Employer's Name: Angelo Iafrate Construction LL	
		Insurance Carrier's No.: 011923002230WC01	

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/10/03	11/12/03	Inpatient Hospitalization	\$25,428.39	\$25,428.39

PART III: REQUESTOR'S POSITION SUMMARY

The request for medical dispute resolution pertains to medical services and treatment provided from 11/10/03 to 11/12/03. To date a total of \$6,803.42 has been paid in connection with this claim. It is our position that reimbursement was improperly determined pursuant to TWCC Rule 134.401(c)(6) which allows for reimbursement at the stop-loss rate of 75% of audited charges when those charges exceed \$40,000.00. The carrier ignored the stop-loss rule by paying this claim using the per diem reimbursement methodology. Under Rule 134.401(c)(6), this claim would be reimbursed at the stop-loss rate of 75% of audited charges, resulting in a reimbursement of \$32,231.81. Based on the clear wording of the rules of the TWCC and recent SOAH decisions, the carrier is liable for an additional sum owed in the amount of \$25,428.39.

PART IV: RESPONDENT'S POSITION SUMMARY

Medical bills in excess of \$40,000.00 do not automatically qualify for stop-loss reimbursement. The requestor has not proven entitlement to any exception showing services provided were unusually extensive and unusually costly for the subject admission. Using the per diem method, this 2-day surgical admission qualifies for \$2,236.00. Further entitlement to reimbursements are allowed for implantables (revenue codes 275, 276, and 278), and orthotics/prosthetics (revenue code 274) based on the hospital's cost plus 10%. The requestor may also be entitled to additional reimbursements for pharmaceuticals in excess of \$250 per dose at cost plus 10%. Having already reimbursed requestor \$6,803.42, the carrier demands reimbursement in an amount not less than \$4,567.42, which is consistent with TWCC Rules and SOAH decisions.

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

This dispute relates to inpatient services provided in a 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 must also involve "unusually extensive services."

The surgical interventions for this admission included: anterior cervical discectomy with bilateral foraminotomy and decompression of the spinal cord, C3-4; anterior cervical discectomy with bilateral foraminotomy and decompression of the spinal cord, C4-5; : anterior cervical discectomy with bilateral foraminotomy and decompression of the spinal cord, C5-6; : anterior cervical discectomy with bilateral foraminotomy and decompression of the spinal cord, C6-7; anterior cervical fusion. C3-4; anterior cervical fusion. C4-5; anterior cervical fusion. C5-6; anterior cervical fusion. C6-7; anterior cervical

instrumentation, DOC plate and screws; and harvesting large left iliac crest bone graft structural through separate incision. The 2-day length of stay is consistent with codes contained on the UB-92 and DRG 520.

After reviewing the documentation provided by both parties, it does appear that this particular admission involved “unusually extensive services.” Accordingly, the stop-loss method does apply.

It appears that the total audited charges are equal to \$42,975.75 and 75% of audited charges equals a reimbursement of \$32,231.81. Given the amount previously paid by the insurance carrier, the health care provider is entitled to an additional reimbursement in the amount of \$25,428.39.

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 **\$25,428.39**. 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 C. McDonald, Jr.

June 9, 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 06/09/2005. 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 en 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: _____