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 HCA HEALTHCARE (St. David's Hospital) 6000 Northwest Parkway, Suite 124 San Antonio, TX 78249-3345	MDR Tracking No.: M4-05-1964-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **Box 28** LIBERTY INSURANCE CORP PO Box 40460 Houston, TX 77240-0460	Date of Injury: Employer's Name: CraftCorps Inc Insurance Carrier's No.: 973374315

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/30/04	**05/09/04**	**Inpatient Hospitalization**	**$16,143.44**	**$959.05**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's rationale for increased reimbursement from the TWCC-60 states, "Per TWCC Guideline, total charges exceed $40K, therefore, stop-loss applies. Implants are not considered auditable." Request for Reconsideration states, our records indicate that the referenced claim has not been paid according to the contract terms as determined by our agreement. Our records indicate that the claim has been underpaid by: $16,143.44.

PART IV: RESPONDENT'S POSITION SUMMARY

Response letter from Liberty Mutual dated 11-25-04 states, We have received the medical dispute filed by HCA Healthcare – St. David's Medical Center for services rendered between the dates of service 4/30/04 – 5/9/04. The bill and documentation attached to the medical dispute has been re-reviewed and our position remains the same. The bill was processed as follows: Total billed charge of $42,084.10, upon conducting a line-by-line audit, it was determined that the charges for implants were excessive. The total charge for implants was deducted from the total billed charges. The implants were then re-priced at usual and customary, per the geographical area and added back to the remainder of charges. Referenced SOAH Docket #453-03-0910-M4 and #M4-02-2243-01 to support payment for a similar claim using this same methodology. Upon appeal, the provider submitted their actual manufacturers invoices; an adjustment was made based on the additional information received.

$42,084.10 Total billed charge
- $10,833.25 Total billed charges for implants
= $31,250.85 Subtotal
+ $ 6,406.00 Implants at cost plus 10%
= $37,656.85 Total

The total amount is less than the Texas Fee Schedule Stop Loss Threshold of $40,000, therefore; payment was made at the Texas Fee Schedule inpatient surgical per diem for the surgical days and the inpatient medical per diem for the rehab days. It was re-calculated as follows:

3 days X $1118.00 (surgical per diem) = $3,354.00
+ 6 days X $870.00 (medical per diem) = $5220.00
+ $ 6,406.25 (cost plus 10% per the hospitals invoices for the implants)
= $14,980.25 (Total payment made per TX FS)

Liberty Mutual does not believe that St. David's Medical Center is due any further reimbursement for services rendered between 4/30/04 – 5/9/04.

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."

After reviewing the documentation provided by both parties, 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 hospital's operative procedure report indicates that a left total knee arthroplasty was performed on 4/30/04. Discharge notes from 5/9/04 indicate that the wound looks great and follow up appointment with Dr. Malone in 1 – 3 weeks. The total length of stay for this surgical admission was 9 days (consisting of 3 days for surgical care and 6 days for rehab care). Per §134.401 (c)(2)(A), the complete treatment of an injured worker is categorized into two admission types: medical or surgical. A per diem amount shall be determined by the admission category. Accordingly, the standard per diem amount due for this surgical admission is equal to $10,062.00 (9 times $1,118, the surgical per diem). In addition, the hospital is entitled to additional reimbursement for implantables/MRIs/CAT Scans/pharmaceuticals as follows:

The documentation provided invoices totaling $5,343.00. Since the reimbursement for implantables is cost plus 10%, the amount due for the implantables would equal $5,877.30.

Therefore, pursuant to Rule 134.401, this dispute is to be paid as follows:

$ 10,062.00 – per diem for a 9-day surgical stay
+ $ 5,877.30 – implantables
= $15,939.30 -- (Sub-Total)
- $14,980.25 – paid by carrier
= $ 959.05 -- (Total Amount Due)

We find that the requestor is entitled to an additional reimbursement for this dispute in the amount of $959.05.

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 **$959.05**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due tat the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Allen C. McDonald, Jr.	June 9, 2005
	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 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: _____