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 6000 Northwest Pkwy. San Antonio, TX 78249-3343	MDR Tracking No.: M4-05-2044-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **Box 19** SISTERS OF MERCY HEALTH SYSTEM James R. Sheffield, III, Attorney Flahive, Ogden & Latson Post Office Drawer 13367 Austin, TX 78711	Date of Injury: Employer's Name: Sisters of Mercy Health System Insurance Carrier's No.: 2720035886

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/24/04	02/28/04	Surgical Admission	$26,120.11	$0.00

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 charges."

PART IV: RESPONDENT'S POSITION SUMMARY

Requestor billed a total of $56,448.49. The Requestor asserts it is entitled to reimbursement in the amount of $42,336.37, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges.

Carrier provided a reference to SOAH Docket No. 453-03-0910.M4 , which in part, concluded that the stop-loss methodology may be allowed, but only if the $40,000 threshold of "audited charges" is exceeded and then only "on a case-by-case" basis. Using the per diem method, this 4 day surgical admission qualifies for $4472 in reimbursement. Further, the Requestor is entitled to reimbursement for implantables in the amount of $11,744.26, based on the hospital's cost plus 10%. Carrier has already reimbursed the Requestor $16,216.26.

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 **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.

In particular, this surgical admission resulted in a total length of stay of 4 days based upon: L4 total laminectomy, decompression of the L4 and L5 nerve roots bilaterally, L4-5 posterolumbar fusion with Collagraft and bone marrow

aspirate, and autogenous right posterior iliac crest bone, harvesting of right posterior iliac crest bone, reconstruction of the right posterior iliac crest with Collagraft, L4-5 posterior lumbar interbody fusion with 14-mm symmetry allograft, diskectomy bilaterally, L4-5, and internal fixation, L4-5. Accordingly, the standard per diem amount due for this admission is equal to $4472.00 (4 times $1,118). In addition, the hospital is entitled to additional reimbursement for implantables/MRIs/CAT Scans/pharmaceuticals.

The documentation provided invoices totaling $10,676.60. Since the reimbursement for implantables is cost plus 10%, the amount due for the implantables would equal $11,744.26.

Therefore, pursuant to Rule 134.401, the reimbursement for this admission is equal to $4,472.00 (per diem for a 4-day surgical stay) plus $11,744.26 (implantables), which equals $16,216.26.

The provider billed for $56,448.49 and received payments totaling $16,216.26. Therefore, considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that **no** additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

Authorized Signature	Typed Name	Date of Order
	Allen C. McDonald, Jr.	May 24, 2004

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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____