MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Spine Hospital of South Texas 18600 N. Hardy Oak Blvd. San Antonio, TX 78258	MDR Tracking No.: M4-05-2099-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address East Central ISD/Rep. Box #: 03 C/o Barron Risk Mgmt Services Inc 613 Northwest Loop 410 #800 San Antonio, TX 78258	Date of Injury: Employer's Name: East Central ISD Insurance Carrier's No.: WC0267144205

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
8-17-04	8-20-04	Inpatient Hospitalization	$20,376.29	$20,376.28

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's rational listed on the Table of Disputed Services states, "Payment is not in accordance with TWCC Fee Guideline. Payment is not in accordance with Acute In-patient Stop-Loss portion of the Fee Guideline. Used by Carrier for Charges for which no "MAR" is established. Unbundling for this service is prohibited per the Fee Guideline. Payment exception code "G" not applied consistently by carrier."

PART IV: RESPONDENT'S POSITION SUMMARY

Response is untimely.

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 3 days. The patient underwent a "1. L3 to sacrum posterolateral fusion. 2. L3 to sacrum Steffee internal fixation. 3. Bone graft harvest left iliac crest plus local bone. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

The Requestor billed $44,178.99. The Respondent reimbursed $12,757.96. Due to the medical information provided, the admission involved "unusually extensive services". Therefore, the stop-loss reimbursement factor of (75%) results in a workers' compensation reimbursement amount equal to $20,376.28 ($33,134.24- $12,757.96).

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 $20,376.28.

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 $20,376.28. 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 McDonald	6-9-05
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: _____