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. Spine Hospital of South Texas 18600 N. Hardy Oak Blvd. San Antonio, TX 78258	MDR Tracking No.: M4-05-2632-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Insurance Co. Box 19 c/o Flahive, Ogden & Latson	Date of Injury: Employer's Name: Lone Star Theatres, Inc. Insurance Carrier's No.: 85002386777

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/22/04	09/25/04	Inpatient Hospitalization	$21,670.32	$383.87

PART III: REQUESTOR'S POSITION SUMMARY

The Commission instructions specifically state that code "F" is to be "used when the IC is reducing payment from the billed amount in accordance with the appropriate TWCC fee guidelines MAR, including when the IC is paying for a generic pharmaceutical at the brand name price…" The carrier has not provided reimbursement to the healthcare provider in accordance with the Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act, which is established pursuant to Texas Administrative Code Section 134.201. Therefore, the healthcare provider respectfully request full reimbursement in accordance with the Medical Fee Guideline for Medical Treatments and Services provided under the Texas Workers' Compensation Act…

PART IV: RESPONDENT'S POSITION SUMMARY

The provider has filed a TWCC-60 along with a Table of Disputed Services. The carrier has several problems with the Table of Disputed Services. First, the provider has miss-added the amount billed. Specifically, it indicated that the amount billed was $47,076.61. However, the provider inflated the amount billed by approximately $16.055. Adding all of the services identified on the Table of Disputed Services totals to approximately $31,021. The provider did not identify code 360 on its Table of Disputed Services but apparently has included it in the amount billed. Secondly, the provider has attached a couple of letters to its TWCC-60 and in those letters, it appears to claim that this is a stop-loss case, but at the same time, the provider has indicted that the Medical Fee Guideline MAR is $35,307.46, which is not sufficient to meet the stop-loss threshold…

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." Per the operative report the procedures performed were bilateral L5-S1 hemilaminectomy; bilateral L4-5, L5-S1 medial facetectomies, foraminotomies L5 and S1 nerve roots; bilateral subtotal diskectomy; L5-S1 positerior lumbar interbody fusion with capital BMP; L5-S1 bilateral PCR cage insertion, 10x22 mm; bilateral L5-S1 posterolateral intertransverse fusions with BMP-autograft; and harvesting of autograft. All procedures were microendoscopic with the exception of the autograft harvesting. 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 total length of stay for this admission was 3 days (consisting of 3 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $3,354.00 (3 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The healthcare provider submitted two invoices totaling $9,697.25; this amount times 10% equals $10,667.01 plus the per diem amount of $3,354.00 equals a reimbursement total of $14,021.01.

The insurance carrier made a payment in the amount of $13,637.14. Based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401©, we find that the health care provider is entitled to a reimbursement amount for these services equal to $383.87.

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 $383.87. 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:

Authorized Signature	Marguerite Foster Typed Name	June 3, 2005 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: _____