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 Plaza Medical Center (HCA) HCA Patient Accounting Services 10030 N. MacArthur Blvd., Suite 100 Irving, TX 75063	MDR Tracking No.: M4-05-2689-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address OLD REPUBLIC INSURANCE CO 901 S MO PAC EXPY BLDG 4 AUSTIN TX 78746-5776 Austin Commission Representative Box 02	Date of Injury: Employer's Name: Insurance Carrier's No.: 900000183

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/04/03	11/08/03	Inpatient Hospitalization	$36,206.55	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Per TWCC guidelines, this claim qualified for the stop loss methodology reimbursement, as charges exceed the $40,000 threshold. Therefore, the entire claim should be paid at 75% of charges. Per the San Antonio Independent School Board vs. TWCC and the Metropolitan Methodist Hospital (Docket No. 453-03-1233.M4), implants should not be removed in stop loss claims. This claim should be reimbursed at 75% of the entire billed charges, including implant charges.

PART IV: RESPONDENT'S POSITION SUMMARY

EGIG reduced the $63,695.50 charge for implants to a fair and reasonable amount of $13,051.13, did a line by line audit, and then reimbursed based upon the stop loss method. The total reimbursement was $41,229.47…

The EGIG reimbursement is correct. SOAH Decision No. 453-00-2092-M4 decided 04/24/01 concluded that a carrier is permitted to reduce charges for implantable to cost plus 10 percent to calculate whether a bill exceeds the stop-loss threshold. This is exactly what EGIG did. That amount exceeded the $40,000 threshold. The fair and reasonable cost of the implantable (cost plus 10%) was added to the audited charges and 75% of that amount was reimbursed. The Medical Advisory Committee recommended a cost plus 10% figure as being a fair and reasonable reimbursement amount in creating the 1992 Guidelines. Nobody opposed the calculation. Cost plus 10% is still a good measure of a fair and reasonable rate for implantable.

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.

The total length of stay for this admission was 4 days (consisting of 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $4.472(4 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit implant invoices; therefore, MDR cannot determine the cost plus 10%.

The Requestor billed the Respondent $103,248.02 and received payments totaling $41,229.47. 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:

		03-24-05
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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____