MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION		
Type of Requestor: ☐ HCP ☐ IE ☐ IC	Response Timely Filed? Yes No	
Requestor's Name and Address Medical Center of Plano	MDR Tracking No.: M4-05-2807-01	
HCA Payment Account Services	TWCC No.:	
10030 N. MacArthur Blvd., Suite 100	Injured Employee's Name:	
Irving, TX 75068		
Respondent's Name and Address Target Corp.	Date of Injury:	
Sedgwick Claims Mgmt Svcs Inc	Employer's Name: Target Corporation	
Attn: Susan Holt	Insurance Carrier's No.:	
Richardson, TX 75080	insurance carrier's No	
Austin Commission Representative Box 39	000093553	

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	То	Amount in Dispute		7 mount Duc
11/13/03	11/15/03	Inpatient Hospitalization	\$31,057.18	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

This claim qualified for stop loss as charges are greater than \$40,000. Therefore, Per TWCC Guidelines, this claim should be paid at 75% of billed charges. Per the San Antonio Independent School District vs. TWCC and Metropolitan Methodist Hospital (Docket No. 453-03-1233-M4), implants should not be removed from stop loss claims. This claim should be paid at 75% of entire billed charges.

PART IV: RESPONDENT'S POSITION SUMMARY

This is a medical fee dispute arising from an inpatient hospital surgical admission, dates of services 11/13/03-11/15/03. Requestor billed a total of \$50,888.75. The Requestor asserts it is entitled to reimbursement in the amount of \$38,166.56, 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.

Medical bills in excess of \$40,000 do not automatically qualify for stop-loss reimbursement. Rather, the per diem rate is the default and preferred method of reimbursement that must be employed unless the hospital justified use of the stop-loss method in a particular case. 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.

Here, the initial \$40,000 threshold has not been exceeded. The "total charges" less "deducted charges" (including personal items, undocumented services, services unrelated to the compensable injury, duplicative charges, upcoded services, unbundled services, implantables, orthotics, prosthetics and pharmaceuticals in excess of \$250 per dose), results in "audited charges" which do not exceed \$40,000. Cost-plus reimbursement for the above-referenced services is applicable as such are included in "deducted charges". It should be noted that Requestor charged \$25,902.00 (more than $\frac{1}{2}$ the total charges for the admission and more than a 500% markup) for implantables only costing less than \$4,500.

Using the per diem methods, this 2 day surgical admission qualified for \$2,236(\$1,118*2 days) in reimbursement less a network discount, for a total payment of \$2,168.92.

Further, the Requestor is entitled to reimbursement for implantables (revenue codes 275, 276, and 278) and orthotics/prosthetics (revenue code 274) IN THE AMOUNT OF \$4,930.61. this is based on the hospital's cost plus 10%. The Requestor may also be entitled to additional reimbursement for pharmaceuticals costing in excess of \$250 per dost. The requestor must document the cost of such pharmaceuticals to Carrier may reimburse at cost plus 10%.

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 2 days (consisting of days in an intense care unit and 2 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to \$2,236 (0 times \$1,560 plus 2 times \$1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

No documentation was provided by the Requestor.

The Requestor billed for \$50,888.75 and received payments for \$7,109.38. 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.

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PART VI: COMMISSION DECISION				
Based upon the review of the disputed he not entitled to additional reimbursement.	althcare services, the Medical Review Division	on has determined that the requestor is		
Findings and Decision by:		0.4/10/05		
	Gail A. Anderson	04/19/05		
Authorized Signature	Typed Name	Date of Order		
PART VII: YOUR RIGHT TO REQUEST A F	IEARING			
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, 7551 Metro Center Drive, Suite #100, 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 DELIVI	ERY CERTIFICATION			
I hereby verify that I received a copy of t	his Decision in the Austin Representative's b	oox.		

Signature of Insurance Carrier: