# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

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|---|---|
| **Type of Requestor:** (x) HCP ( ) IE ( ) IC | **Response Timely Filed?** (x ) Yes ( ) No |
| Requestor's Name and Address<br>Tenet Healthcare/Trinity Medical Center<br>2401 Internet Boulevard #110<br>Frisco, TX 75034 | MDR Tracking No.: M4-05-3388-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br>North American Specialty Ins./Rep. Box #: 22<br>C/o JI Specialty Services<br>P.O. Box 26655<br>Austin, TX 78755 | Date of Injury:<br>Employer's Name: Bridgeport Tank Trucks Inc.<br>Insurance Carrier's No.: 50980000016 |

## PART II: SUMMARY OF DISPUTE AND FINDINGS

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 5-4-04 | 5-7-04 | Inpatient Hospitalization | $37,371.80 | $33,292.12 |
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## PART III: REQUESTOR'S POSITION SUMMARY

Position statement of January 3, 2005 states in part "…Our findings reveal this claim has not been paid according to the hospital fee guideline…This claim in the amount of $131,380.13 is an inpatient surgical claim in which charges exceed $40,000, the stop loss threshold amount, however payment is not based on this methodology… we received partial payment in the amount of $61,159.09…"

## PART IV: RESPONDENT'S POSITION SUMMARY

Position statement of January 25, 2005 states in part "We have reviewed the submitted documentation; and feel that our original review was appropriate… Since costs of implants were never received the fees are unpaid. In view of this, we are unable to recommend any additional allowance…"

## 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 based upon (an anterior/posterior spinal fusion at L4-L5 with instrumentation). Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

The Table of Disputed Services list Rev. Code 270 (Central Supply) and Rev. Code 278 (Supply-Other Implant) in dispute. The Requestor billed $15,979.70 Rev. Code 270 and the Respondent reimbursed $4,079.69. Requestor failed to provide any information to support additional reimbursement.

The Requestor billed $44,389.50 for Rev. Code 278 (Supply-Other Implant) and the Respondent did not allow any reimbursement. 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 $33,292.12.

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 $33,292.12.

**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 $33,292.12. 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 | 4-19-05 |
|---|---|---|
| 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, 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 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: _____