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 Twelve Oaks Medical Center c/o Hollaway & Gumbert 2701 Kirby Dr., Ste. 1288 Houston, TX 77098	MDR Tracking No.: M4-05-3544-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address ACE American Insurance Co. c/o ACE USA/ESIS Box 15	Date of Injury: Employer's Name: Eagle construction & Environment Insurance Carrier's No.: C290C0870012

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/29/04	**01/31/04**	**Inpatient Hospitalization**	**$28,935.93**	**$1,861.18**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary states in part, "…Based upon review by the insurance carrier, ACE USA ('ACE'), and its audit department, alleges that the aforementioned claim has been properly paid. On the contrary, specifically, per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%. Per Rule 134.401 (c)(6)(A)(v), the only charges that may be deducted from the total bill are those for personal items… and those not related to the compensable injury. Moreover, Rule 134.401(c(6)(A)(v) states what the carrier can deduct in the audit. The carrier should not confuse the carve-out items identified in section (c)(4) as items that can be deducted in an audit or paid separately. Therefore, reimbursement for the entire admission including charges for items in (c)(4) is calculated by the stop-loss reimbursement amount of 75% times the total audited charges. Therefore, the fees paid by ACE do not conform to the reimbursement section of Rule 134.401…"

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a Position Summary.

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." The discharge summary indicated the injured worker had severe pain syndrome and failed non-operative care. An anterior cervical diskectomy and fusion and instrumentation at C5-6 was performed and postoperatively the injured worker did will and was ambulatory on post-op day 1. The discharge summary also indicates the injured worker did very well and was "discharged home with good-looking incisions, x-rays and medications." 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 2 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $2,236.00 (2 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

DePuy Spine Invoice:	$3,339.30 x 10% = $3,673.23	Total Per Diem Reimbursement:	$7,444.72
TMC Orthopedic Invoice:	$1,395.90 x 10% = 1,535.49	Less Carrier Reimbursement:	(5,583.54)
Total for Implantables:	$5,208.72	Reimbursement Amount Due:	$1,861.18
LOS of 2 days @ $1118.00/day:	2,236.00		

The Requestor billed $44,526.96; the EOB submitted shows the Respondent made payment in the amount $5,583.54 and used PEC "C". Neither party has submitted convincing evidence of a contract between the Requestor and the Respondents PPO provider. 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 an additional reimbursement amount for these services equal to $1,861.18.

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 $1,861.19. 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:

	Marguerite Foster	04/13/05
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: _____