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. Vista Medical Center Hopsital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M4-05-3755-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Protection Insurance Box 42 c/o Broadspire P.O. Box 701809 Dallas, TX 75370	Date of Injury: Employer's Name: DX Holding Co., Inc. Insurance Carrier's No.: 4560144154

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/24/04	03/01/04	Inpatient Hospitalization	$56,453.94	$1,854.35

PART III: REQUESTOR'S POSITION SUMMARY

TWCC Rule 134.401 provides the rules regarding reimbursement for Acute Care In-patient Hospital Fee services. Specifically, reimbursement consists of 75% of remaining charges for the entire admission, after a Carrier audits a bill… This figure is presumptively considered to be "fair and reasonable" in accordance with the preamble of TWCC Rule 134… Further, the TWCC stated that the stop-loss threshold increased hospital reimbursement and will ensure fair and reasonable rates for hospitals and ensure access to quality health care for injured workers…

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a position summary; however, in a letter to the Requestor, dated June 24, 2004, the Respondent stated in part, "…The DRG which was submitted and accepted is 209 which is a DRG reflecting the lack of any complications or co-morbidities during this hospitalization. Consequently, there is no rationale for considering that this particular hospital admission is in any way unusual or extensive. The hospital length of stay of six days does not substantially exceed the average mean length of stay for this particular DRG. No other extenuating factors that render this case atypical were evident on review of the file… Additionally, this was a 6 day inpatient stay and 3 days were not pre-certified. Therefore, we have been unable to make per diem reimbursement for the 3 days…"

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 documents that the patient underwent a right total knee replacement and tolerated the procedure intraoperatively and postoperatively well. According to the Operative Report the patient did exhibit a segment of ST depression, indicating possible isohemia, however, he had cardiac clearance prior to surgery and is know to have some arrhythmia; however, he was in normal sinus rhythm at the end of the case. 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 6 days (consisting of 1 day in an intense care unit and 5 days for surgical); however, per the Respondent, three days of the hospital stay were not preauthorized. Accordingly, the standard per diem amount due for this admission is equal to $3,796.00 (1 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: The requestor submitted an invoice from Stryker Orthopaedics in the amount of $9,359.00. Total reimbursement for implantables is $10,291.60 ($9,359.00 x 10%). Total for reimbursement for this hospital admission should be $14,087.60.

The insurance carrier paid the health care provider a total of $12,233.22. 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 $1,854.35.

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 $1,854.35. 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.

Decision and Order by:

Authorized Signature	Marguerite Foster Typed Name	May 19, 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: _____