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 HOUSTON COMMUNITY HOSPITAL PO Box 11586 Houston, TX 77093	MDR Tracking No.: M4-05-3902-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address ST. PAUL MERCURY INSURANCE Austin Commission Representative Box 05	Date of Injury: Employer's Name: Indiana Lumbermen's Insurance Insurance Carrier's No.: 82-610559

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
08/09/04	**08/13/04**	**Inpatient Hospitalization**	**$88686.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Carrier did not pay claim at the stop-loss. Requestor is requesting reimbursement at the stop-loss and usual and customary. The TWCC-60 indicates total amount billed is $125,517.60 and $88,686.00 is the amount in dispute. Requestor filed request for reconsideration requesting carrier to reconsider its actions because of dissatisfaction with the amount of reimbursement. The carrier has not offered sufficient evidence to justify or explain the case specific methodology that was used in this particular case; rather, it would appear that the carrier is improperly reducing reimbursement using a standard rate of reimbursement that it applies to all cases.

PART IV: RESPONDENT'S POSITION SUMMARY

Based on a Hospital Bill Review Report (audit date of 12/27/04) performed by Forte', payment of $4914.00 was recommended. The carrier reimbursed $4914.00 for 4 days inpatient hospital stay (1 day in intensive care unit and 3 days in surgical.) EOB stated: Payment based on the assigned per diem amount per the 1997 Texas Inpatient Hospital Fee Guideline, payment reduced according to fair and reasonable, previously recommended amount has not been changed, and payment for these services is included in the per diem amount.

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."

Based on discussions with medical staff and reviewing the documentation provided by both parties, it does **not** appear that this particular admission reached the stop-loss threshold or involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 4 days (consisting of 1 day in the intensive care unit and 3 days in surgical unit). The majority of this bill ($93,600) was for OR BARI/ 360 180 MIN and 270 MIN. No documentation was provided by the Requestor to explain or determine how these charges were derived.

Therefore, these charges were excluded from the total audited charges, ($125,517 less $93,600 equals $31,917), and no longer exceeds the $40,000 required to qualify for the stop-loss method.

Reimbursement is based on a global fusion and inferior posterior discectomy, instrumentation and placement of cage for herniated disk of lumbar spine at L4-5, L5-S1. Accordingly, the standard per diem amount due for a total length of stay for this surgical admission of 4 days is equal to $4,914 (1 times $1,560 plus 3 times $1,118). No implant charges were listed on the UB-92.

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:

	Allen McDonald	05/02/05
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, Mail Stop 35, 7551 Metro Center Dr., 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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____