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 Memorial Hermann Hospital System 3200 Southwest Freeway, Suite 2200 Houston, Texas 77027	MDR Tracking No.: M4-05-3957-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Amerisure Mutual Insurance Company C/O Burns, Anderson, Jury & Brenner P O Box 26300 Austin, Texas 78755-0300 Box 47	Date of Injury: Employer's Name: Merit Electric Company Insurance Carrier's No.: 0000949682 001

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/02/04	02/06/04	Surgical Admission	$5,017.50	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

"The hospital submitted its complete medical bill on February 11, 2004, and my client received a partial payment of $44,427.00 on March 15, 2004. My client initially requested reconsideration of its bill on April 27, 2004 and re-faxed it the carrier on May 12, 2004. The carrier refused to pay any additional money on the appeal and the healthcare provider requests medical fee dispute."

PART IV: RESPONDENT'S POSITION SUMMARY

"In response to the above referenced Medical Dispute Resolution request, the carrier hereby notifies all parties that we are standing by our previous audit recommendations and payment for the medical bill from Provider's hospital for services rendered on February 2, 2004."

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 additional 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 information provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." The provider did not submit an operative report indicating what procedure was performed; however, the provider in their position statement indicates that a posterior fusion L5-S1 was performed. No complications were noted in the position statement. 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 provider did not submit any invoices indicating the amount billed for the implantables. Therefore, MDR cannot determine the charges of the implantables and no reimbursement is recommended for the implantables.

The carrier made reimbursement for the 4-day stay in the amount of $44,427.00. Based on a per diem reimbursement in the amount of $4,472.00 (4 day-stay x $1,118.00 = $4,472.00). No additional reimbursement is recommended.

Therefore, 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 not entitled to additional reimbursement.

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.

Ordered by:

	Michael Bucklin	08/02/05
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, 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: _____