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 Presbyterian Hospital of Plano 3255 W. Pioneer Parkway Arlington, TX 76013	MDR Tracking No.: M4-05-3985-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Dallas Fire Ins. Co. /Rep. Box #: 17 C/o Downs, Stanford, P.C. 2001 Bryan St., Suite 4000 Dallas, TX 75201	Date of Injury: Employer's Name: 1st Odyssey Group Inc Insurance Carrier's No.: A21970

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
6-22-04	6-26-04	Inpatient Hospitalization	68,720.03	00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position statement of December 12, 2004 states in part "…This claim has been reimbursed… it was not processed according to the Acute Care Hospital Fee Guidelines… Per TWCC guidelines, charges greater than $40,000 are to be paid at 75% of billed charges. In the case of carve-outs identified by revenue codes, the whole bill is paid according to the stop-loss provision if the threshold is reached. Therefore there will be no overlap between carve-outs identified by pharmacy carve outs and carve outs identified by revenue codes and stop-loss, allowing analysis of each factor…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement of February 8, 2005 states in part, "… Requestor seeks additional reimbursement for in-patient services… Respondent audited the bill and reduced it to $37,312.50… Claimant underwent surgery… without ICU/CCU days… Based on the performed procedure, as well as the length of stay under the Acute Care Inpatient Hospital Fee Guidelines, Requestor invoked the Stop-Loss provision of Commission Rule 134.401 and sought reimbursement of $141,481.70. Respondent properly paid $37, 312.50 base upon the documentation submitted by Requestor using the denial code "F" – reduced per Fee Guidelines… Requestor has failed to document exactly how or why the services it provided were unusually extensive or costly, it is due not further reimbursement… Nowhere in any of the submitted documentation does Requestor indicate the services were unusually extensive or costly. Nothing in the documentation describes complications of any nature; nothing shows the procedure was anything but routine… it has not shown the procedure to be unusually costly or extensive… it has failed to meet the two-pronged Stop-Loss criteria, and merits no additional monies".

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." 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 4 days (consisting of 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $4,472.00 (4 times $1,118). The Respondent paid $32,840.50 for Supplies/Implants. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit any medical documentation that the surgery involved unusually extensive services nor did the requestor submit any implant invoices; therefore, MDR cannot determine the cost plus 10%.

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:

	Roy Lewis	4-18-05
Authorized Signature	Typed Name	Date of Decision

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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____