MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: ☒ HCP ☐ IE ☐ IC	**Response Timely Filed?** ☐ Yes ☒ No
Requestor's Name and Address Twelve Oaks Medical Center c/o Hollaway & Gumbert 3701 Kirby Drive, Suite 1208 Houston, TX 77098	MDR Tracking No.: M4-05-4109-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address FIDELITY & GUARANTY INSURANCE CO PO BOX 13367 AUSTIN TX 78711-3367 Austin Commission Representative Box 19	Date of Injury: Employer's Name: Bed Bath and Beyond Inc. Insurance Carrier's No.: 900000257

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2/04/04	**2/05/04**	**Inpatient Hospitalization**	**$25,137.66**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Insurance Carrier failed to pay per TWCC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline and SOAH decision 453-04-3600.M4. Per TWCC Rule 134.401(c)(6) and SOAH decision 453-04-3600.M4, claim pays @ 75% of total charges as charges exceed $40,000.00 stop-loss threshold. Insurance Carrier further failed to audit according to TWCC Rule 134.401(c)(6)(A)(v).

PART IV: RESPONDENT'S POSITION SUMMARY

…Medical bills in excess of $40,000 doe not automatically qualify for stop-loss reimbursement. Rather, the per diem rate is the default and preferred method of reimbursement that must be employed unless the hospital justified use of the stop-loss method in a particular case. The stop-loss methodology may be allowed, but only if the $40,000 threshold of "audited charges" is exceeded and then only "on a case-by-case" basis. Here, the initial $40,000 threshold has not been exceeded. The "total charges" less "deducted charges" (including personal items, undocumented services, services unrelated to the compensable injury, duplicative charges, upcoded services, unbundled services, implantables, orthotics, prosthetics and pharmaceuticals in excess of $250 per does), results in "audited charges" which do not exceed $40,000. Cost-plus reimbursement for the above-referenced services is applicable as such are included in "deducted charges". Furthermore, Requestor has not proven entitlement to any exception to the preferred per diem method. Such proof requires Requestor to show the services provided were unusually extensive and unusually costly for the subject admission. Requestor has failed to sustain the preferred/default method of reimbursement is the per diem method. Using the per diem method, this one day surgical admission qualified for $1,118 in reimbursement. Further, the Requestor is entitled to reimbursement for implantables (revenue codes 275, 276 and 278) and orthotics/prosthetics (revenue code 274) in the amount of cost plus 10%. The Requestor may also be entitled to additional reimbursement for pharmaceuticals costing in excess of $250 per dose. The Requestor must document the cost of such pharmaceuticals so Carrier may reimburse at cost plus 10%.

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 1 days (consisting of 0 days in an intense care unit and 1 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $1,118 (0 times $1,560 plus 1 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

No documentation was provided by the Requestor.

The Requestor billed for $41,023.52 and received payments for $5,629.98. 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:

	Gail A. Anderson	04/14/05
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, 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: _____