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 Tenet Healthcare/Park Plaza Hospital 2401 Internet Blvd., Suite 110 Frisco, TX 75034	MDR Tracking No.: M4-05-4139-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address ACE AMERICAN INSURANCE CO 9901 BRODIE LN STE 160 PMB 225 AUSTIN TX 78748-5612 Austin Commission Representative Box 15	Date of Injury: Employer's Name: Kellogg Brown & Root Inc. Insurance Carrier's No.: 900000272

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
5/19/04	**5/22/04**	**Inpatient Hospitalization**	**$48,062.75**	**$48,062.75**

PART III: REQUESTOR'S POSITION SUMMARY

On behalf of Tenet Healthcare, we have reviewed the claim and payment for this hospital admission. Our findings reveal this claim has not been paid according to the hospital fee guideline published by the Texas Workers Compensation Commission. This claim in the amount of $85,336.25 is an inpatient surgical claim in which charges exceed $40,000, the stoploss threshold amount, however payment is not based on this methodology and we request you to review this for Medical Dispute Resolution as a Fee Dispute.

PART IV: RESPONDENT'S POSITION SUMMARY

Ace American Insurance Company has reviewed medical documentation submitted from the Requestor, Tenet Healthcare, for dates of services of 5/19/04 through 5/22/04 in the amount of $85,307.00. It is the Carrier's position to stand on CorVel's review that the adjusted amount of $15,917.50 reimbursed per Texas Workers' Compensation Adopted Rules was correct. Additional payment will be consider for the implants when the hospital invoices are received, as indicated on the Explanation of Review.

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 about the procedures and reviewing the documentation provided by both parties, it **does** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 3 days based upon L5 Gill procedures; total L2/L3/L4 laminectomies; bilateral L2-3, L3-4; L4-5 and L5-S1 foraminotomies; bilateral L3, L4, L5 and S1 nerve root exploration; L5-S1 near transverse fusion using right iliac crest bone graft; L5-S1 internal fixation with Synthese Quick-X; and fat graft.. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

The total audited charges associated with this admission equals $85,307.00. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to $63,980.25. The Requestor billed the Respondent $85,336.25 and received payments of $15,917.50.

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 $48,062.75.

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 $48,062.75. 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.

Ordered by:

	Allen McDonald	04/11/05
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: _____