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 Spine Hospital of South Texas 18600 N. Hardy Oak Blvd. San Antonio, TX 78258	MDR Tracking No.: M4-05-4208-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address AMERICAN MANUFACTURERS MUT INS CO PO BOX 162443 WESTLAKE STATION AUSTIN TX 78716-0000 Austin Commission Representative Box 42	Date of Injury: Employer's Name: Insurance Carrier's No.: 900000322

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/17/04	**11/21/04**	**Inpatient Hospitalization**	**$40,686.98**	**$8,332.51**

PART III: REQUESTOR'S POSITION SUMMARY

There is no negotiated contractual agreement with the Carrier. The Carrier has not provided reimbursement in accordance with the contract provisions. A PPO reduction was incorrectly taken by the Carrier. Payment is not in accordance with TWCC Fee Guidline. Payment is not in accordance with Acute Inpatient Stop-Loss portion of the Fee Guideline. Used by Carrier for charges for which no "MAR" is established. Documentation not requested within 14 days of receipt of medical bill. All TWCC-required documentation has been submitted to Carrier. No explanation of missing documentation forwarded by Carrier in compliance with TWCC Administrative Code. Sufficient documentation of signature on medical documenation.

PART IV: RESPONDENT'S POSITION SUMMARY

The provider has failed to meet its burden of proof to establish that its charges and the amount requested are "fair and reasonable," and comply with Section 413.011(b) of the Texas Labor Code and commission rules. The Carrier's reimbursement complies with the requirement of section 413.011(b) of the Texas Labor Code and commission rules and is "fair and reasonable."

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 0 days in an intensive care unit and 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $4,472 (0 times $1,560 plus 4 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:
Requestor provided invlices in the amount of $21,775.23 ($520.00; $538.00; $4,935.73; and $15,781.50). Cost plus 10% = $23,952.75.

The Requestor billed theRespondent $40,248.90 and received payments totaling $5,768.50. 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 $8,332.51.

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 $8,332.51. 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:

Authorized Signature	Typed Name	04-06-05 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: _____