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 Leon E. Pegg, Attorney for Holloway & Gumbert on behalf of Corpus Christi Medical Center 3701 Kirby Drive, Ste. 1288 Houston, TX 77098	MDR Tracking No.: M4-05-4533-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **Box 28** Liberty Mutual Insurance Group 2875 Browns Bridge Road Gainesville, GA 30504	Date of Injury: Employer's Name: Northland Investment Corp Insurance Carrier's No.: 973403925

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/24/04	**02/28/04**	**Inpatient Hospitalization**	**$12,701.40**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

The 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

We have received the medical dispute filed. The bill and documentation attached to the medical dispute has been re-reviewed and our position remains the same. Our rationale and calculations are as follows: Total billed charge is $73,598.00 – $27,736.00, the total charge for implants which we deemed excessive = $45,862.00 x 75% stop-loss reimbursement factor = $34, 396.50, + implants re-priced at fair and reasonable per hospitals own invoices submitted with appeal @ $11,869.75 = $46,266.25, + $32.60 interest = $46,298.95.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in a 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 must also involve "unusually extensive services."

There is no documentation to support the diagnosis and procedure codes provided on the UB-92 form, nor documentation to indicate cost of implantables.

The requestor billed for charges relating to implantables in the total amount of $27,736.00 and the requestor provided a copy of the carrier's EOB dated 6/9/04 that indicated payments received for the implantables were in the amount of $8,100.60 (total reimbursement = $42,497.10). The carrier's (respondent's) position and EOB copy dated 2/7/05 offer a different payment for implantables that reflects an amount of $11,869.75 (total reimbursement with interest = $46,298.85). There is a noted discrepancy of $3,801.75 in the differing EOBs for the total amount reimbursed Corpus Christi Medical Center.

After reviewing the positions of both parties, there is nothing to indicate 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 surgical admission was 4 days (consisting of 4 days for surgical care and 0 days in intensive care). Accordingly, the standard per diem amount due for this admission is equal to $4,472.00 (4 times $1,118.00, the surgical per diem). In addition, the hospital is entitled to additional reimbursement for implantables/MRIs/CAT Scans/pharmaceuticals. Based on a review of numerous medical disputes and our experience, the average mark-up for implantables in many hospitals is 200%. Since the requestor did not present any documentation supporting their costs, this average mark-up has been applied to the charged amount derived from the UB-92 form in order to determine if the requestor is entitled to further remuneration. Based on a charge of $27,736.00, it appears that the cost for these implantables was approximately $13,868.00 (charged amount divided by 200%). Since the reimbursement for implantables is cost plus 10%, the amount due for the implantables would equal $15,255.00. The calculation for this admission would equal a total of $19,727.00 (surgical per diem total $4,472.00 + implantables $15,255.00 = $19,727.00).

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared to and despite the differing amounts the insurance carrier indicated was previously paid, 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:

	Allen C. McDonald, Jr.	June 9, 2005
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 06/09/2005. 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 in the Austin Representative's box.

Signature of Insurance Carrier: ______________________ Date: ______________