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 Twelve Oaks Medical Center C/o Hollaway & Gumbert 3701 Kirby Drive, Suite 1288 Houston, TX 77098-3926	MDR Tracking No.: M4-05-4880-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Hartford Casualty Ins. Co./Rep. Box # 27 P.O. Box 4626 Houston, TX 77210	Date of Injury: Employer's Name: IPA Management Associates, Inc. Insurance Carrier's No.: 978C 11206

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
3-3-04	3-7-04	**Inpatient Hospitalization**	$35,568.61	$6,728.33

PART III: REQUESTOR'S POSITION SUMMARY

Position of March 24, 2005 states in part "… To date, a total of $4,564.67 has been paid in connection with this claim It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines… Specifically on the dates March 3, 2004 through March 7, 2004, ___ received treatment at our client's facility relating to a principal diagnosis of "complication due to other internal orthopedic device, implant and graft." Because ___'s admission was inpatient, this claim would be reimbursed pursuant to TWCC Rule 134.401… Based on the clear wording of the rules of the TWCC, the carrier is liable, after the additional 8% allowed under the First Health PPO contract, for an additional sum owed our client in the amount of **$35,568.61**…"

PART IV: RESPONDENT'S POSITION SUMMARY

A position statement was not submitted. However, the Respondent's rationale on the Table of Disputed Services states, "Nothing to support costly extensive services to allow for stop loss".

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." The operative report dated March 3, 2004 indicates the "Preoperative Diagnoses: Nonunion of posterior lumbar interbody arthrodesis at L5-S1" and the surgeon performed "1. Exploration of lumbar spinal fusion mass. 2. Excision of pseudarthorsis L5-S1. 3. Posterolateral arthrodesis L5-S1. 4. Posterior spinal segmental instrumentation with DePuy titanium Monarch rod and screws L5-S1 5. Harvesting of left posterior iliac crest morcellized autograft through a separate fascial incision. 6. Insertion of lumbar epidural catheter at L4 for postoperative pain management 7. Bilateral revision lumbar decompression with laminectomy, foraminotomy and nerve root decompression at L5-S1". 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). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor submitted an invoice for implantables totaling $6,201.00.

Total of Implantables: $6,201.00 x 10% = $6,821.00 Total audited charges: $4,472.00 + $6,821.00 = $11,293.00

The Requestor billed $58,164.18; the Respondent reimbursed the healthcare provider $4,564.67 (per diem amount + whole blood less PPO adjustment).

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 $6,728.33 ($11,293.00 - $4,564.67).

PART VI: COMMISSION DECISION

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 $6,728.33. 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.

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: _____