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 THE METHODIST HOSPITAL PO Box 1866 Fort Worth, TX 76101	MDR Tracking No.: M4-05-5109-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **Box 42** Lumbermens Mutual Casualty PO Box 189132 Plantation, FL 33318-9132	Date of Injury: Employer's Name: Office Depot, Inc. Insurance Carrier's No.: 4610062473

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
06/30/04	07/12/04	Surgical Admission	$56,426.35	$56,426.35

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's rationales for increased reimbursement per the TWCC-60 states, "Should pay stop loss 75% of billed charges. The request for reconsideration states, "This claim was billed with charges in excess of $40,000.00. Rule 134.401(c)(6) describes this amount as eligible for "stop Loss" and provides instruction in calculation of the "stop loss" reimbursement. Per Rule 134.401(c)(6)(A)(i)(III): to be eligible for stop loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop loss threshold. This stop loss threshold is established to ensure compensation for unusually extensive services required during an admission. Once the bill has reached the minimum Stop-Loss threshold of $40K, the entire admission will be paid using the Stop-Loss reimbursement factor of 75%. The only charges that may be deducted from the total bill are those for personal items and those not related to the compensable injury. Rule 134.401(c)(6)(A)(v) state what the carrier can deduct in the audit. According to these calculations, there is a balance due of $62,929.44.

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's rationale for maintaining the reduction or denial per the TWCC-60 states, "The provider has failed to meet it's burden of proof to establish that its charges and the amounts requested are "fair and reasonable", and comply with Section 413.011(h) 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." EOB from carrier indicates Total charges: $117,696.25; Reduction amount; $92,353.50; Total allowance $25,342.75. Explanation Codes, F- Fee Guideline MAR Reduction; N – Not Appropriately Documented.

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). 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 appear that this particular admission involved "unusually extensive services." The total charges associated with this admission are $117,696.25; and, the unusually extensive services include 12 inpatient surgical hospital days for a posterior pedicle instrumentation with posterior lateral fusion with cancellus allograft at L2 through S1 on 06-30-04 and anterior L5-S1 discectomy and fusion with femoral

allograft and buttress plate and screw fixation on 07-07-04. The injured worker's postoperative course was complicated by postoperative ileus, which resolved on its own. 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 $117,696.25. This amount multiplied by the stop-loss reimbursement factor (75%) results in a reimbursement amount equal to $88,272.19. The amount the carrier has already paid to the provider ($25,342.75) is to be deducted from the SLRF to determine the remaining amount due of $62,929.44. However, the TWCC-60 filed by the health care provider shows only $56,426.35 as the amount in dispute. While there is no explanation regarding this difference in calculations, it would not be appropriate for the Division to order a higher level of reimbursement than what was requested.

Based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), Medical Review finds that the health care provider is entitled to an additional reimbursement amount of $56,426.35.

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 **$56,426.35**. 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 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 _____. 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, Mail Stop 35, 7551 Metro Center Dr., 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 and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____