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/RHD Medical Center 2401 Internet Blvd., #110 Frisco, TX 75034	MDR Tracking No.: M4-05-6299-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Casualty Co. of Reading, PA/Rep. Box #: 47 C/o Stone Loughlin & Swanson, LLP P.O. Box 30111 Austin, TX 78755	Date of Injury: Employer's Name: DAL Tile Corp. Insurance Carrier's No.: 3A815961

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
8-19-04	8-23-04	Inpatient Hospitalization	$73,412.26	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of March 31, 2005 states, "… On behalf of Tenet Healthcare… our findings reveal this claim has not been paid according to the hospital fee guideline… In reviewing the payment on this account, it appears only the TWCC per diem amount was paid less and incorrect PPO discount. Implants appear to have been carved out… There is no contract language to allow for a discount off the TWCC allowable or one line item of the claim…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position summary of April 25, 2005 states, "…Carrier reimbursed Provider $3,354 less a network reduction, for actual reimbursement of $2,992. Provider did not submit invoices for the implants. Therefore, it was not reimbursed for the implants… This case does not involve an unusually lengthy stay, unusually extensive services by Provider, or services that were unusually costly to Provider… this case involves a routine hospital stay in which Provider performed routine services for a routine operation…"

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 requestor did not provide any medical information for review. The UB-92 lists the "Prin Diag 722.83"; postlaminectomy syndrome lumbar region and "Prin. Procedure 81.03; lumbar & lumbosacral fusion posterior technique. 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). The carrier paid $2,992.00 for Rev. Code 120 (Semi-Private Room) based on a network reduction. Neither the Requestor nor the Respondent provided a copy of the PPO contract. Therefore, the standard per diem amount applies. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CATscans/pharmaceuticals) as follows: However, the requestor did not submit any medical information that the surgery involved unusually extensive services nor did the requestor submit any implant invoices; therefore, MDR cannot determine the cost plus 10%.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, 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:

	Roy Lewis	6-8-05
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, 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: _____