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 Rio Grande Regional Hospital C/o Hollaway & Gumbert 3701 Kirby Drive, Suite 1288 Houston, TX 77098-3926	MDR Tracking No.: M4-05-6351-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Zurich American Ins. Co./Rep. Box #: 19 C/o Flahive, Ogden & Latson 505 West 12th Street Austin, TX 78701	Date of Injury: Employer's Name: MO VAC Service Co. ETAL Insurance Carrier's No.: 2230105573

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4-12-04	4-21-04	**Inpatient Hospitalization**	$20,411.39	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of May 4, 2005 states, "…To date, a total of $12,669.00 has been paid in the connection with this claim. It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines…Because ___'s admission was inpatient, this claim would be reimbursed pursuant to TWCC Rule 134.401… According to Rule 134.401(c)(6), this claim would be reimbursed at the stop-loss rate of 75% as the total audited charges exceed the minimum stop-loss treshold of $40,000 resulting in a reimbursement of $33,080.39. Based on the clear wording of the rules of the TWCC, the carrier is liable for an additional sum owed our client in the amount of $20,411.39… ".

PART IV: RESPONDENT'S POSITION SUMMARY

Position summary of April 27, 2005 states, "…There is no evidence submitted by the hospital demonstrating that the services provided by the hospital were unusually extensive. There is no evidence of "complications, infections, or multiple surgeries" requiring additional services the hospital for the admission. This admission was for the purpose of addressing an infection. This is not a surgical admission during which a subsequent infection resulted requiring additional services on the part of the hospital…"

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 UB-92 lists the "Prin. Diag" code as "996.67"; Inf &Inflam – oth intrl orth device implant & Graft and "Prin. Proc" code as "78.67"; removal if implanted device from tibia & fibula. 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 9 days (consisting of 9 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $10,062.00 (9 times $1,118). The Respondent reimbursed $10,062.00. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The Respondent reimbursed $2,607.00 for implants (Rev code 278). The Requestor did not provide any medical reports and did not submit 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	6-14-05
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: _____