MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Texas Orthopedic Hospital C/o Hollaway & Gumbert 3701 Kirby Drive, Suite 1288 Houston, TX 77098-3926	MDR Tracking No.: M4-05-6413-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Co./Rep. Box #: 54 P.O. Box 12029 Austin, TX 78711-2029	Date of Injury: Employer's Name: Glenn Dugger Insurance Carrier's No.: 99E0000368040

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4-8-04	4-13-04	**Inpatient Hospitalization**	$23,852.00	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of May 6, 2005 states, "… The carrier allowed and paid on 3 days of the patient's 5-day admission. After deducting all charges related to the 2 days that were not allowed, our review shows the carrier failed to price our client's claim correctly… 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 $30,992.25. 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 $23,852.00… ".

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement is untimely.

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 of April 8, 2004 indicates the patient underwent "1. Application of Ilizarov external fixation, complex fixator, left lower extremity. 2. Double level bone transport with double level osteoplasty, left lower extremity. 3. Osteoplasty lengthening, proximal tibia, left lower extremity. 4. Osteoplasty lengthening distal tibia, left lower extremity. 5. Treatment of left tibial nonunion with operative treatment. 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.

In particular, this admission resulted in a hospital stay of 5 days. In review of all of the information submitted, 3 days were preauthorized and no information was provided for the extended stay (2 days). Therefore, the total length of stay for this admission was 3 days (consisting of 3 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $3,354.00 (3 times $1,118). The Respondent reimbursed $3,354.00 for Rev. Code 120 (Room-Board/Semi) and $3,786.25 for implants. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit an invoice for implantables.

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: _____