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.: M4-05-6453-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Hartford Underwriters Ins./Rep. Box #: 27 P.O. Box 4626 Houston, TX 77210	Date of Injury: Employer's Name: Newton Schwartz SR Insurance Carrier's No.: 978C 59038

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4-15-04	4-17-04	**Inpatient Hospitalization**	$23,918.85	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of May 12, 2005 states, "… It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines… Because ___ admission was inpatient, this claim would be reimbursed pursuant to TWCC Rule 134.401… According to Rule 134.401(c)(6), this claim would then be reimbursed at the stop-loss rate of 75% as the total audited charges exceed the minimum stop-loss treshold of $40,000…".

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement was not submitted. The Respondent's rational listed on the Table of Disputed Services states, "Provider has not shown costly extensive services. Provided nor are charges w/o implants beyond 40,000."

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** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 2 days. The operative report of April 15, 2004 indicated the patient underwent "1. Anterior cervical diskectomy and decompression of spinal cord nerve root C5-6. 2. Anterior cervical diskectomy and decompression of spinal cord nerve root C6-7. 3. Anterior cervical interbody arthrodesis C5-6. 4. Anterior cervical interbody arthrodesis C6-7. 5. Anterior cervical instrumentation C5-7 with DePuy titanium plate. 6. Harvesting of left anterior iliac crest structural autograft x2."

The Requestor allowed an "Allowance" of $12,723.01. This "Allowance" reduced the total charges to $28,318.97 ($41,041.98 - $12,723.01). The admission did not exceed the stop loss threshold of $40,000. Therefore, 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.

According to the Requestor's Table of Disputed Services, $23,918.85 ($28,318.97 - $4,400.12 (amount paid by the Respondent)) is the amount in dispute.

The total length of stay for this admission was 2 days (consisting of 2 days for surgical). Accordingly, the standard per diem amount due

for this admission is equal to $2,236.00 (2 times $1,118). The Respondent reimbursed $2,057.11 ($2,236.00 – 178.88 (PPO contract)) and $2,343.00 for implants. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not 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.

Ordered by:

	Roy Lewis	6-6-05
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, 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: _____