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 Memorial Hermann Hospital System C/o Sullings Johnston Rohrbach and Magers 3200 S.W. Freeway, Ste. 2200 Houston, TX 77027	MDR Tracking No.: M4-05-6606-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address City of Houston/Rep. Box #: 42 C/o Cambridge Integrated Services 7324 S.W. Freeway #700 Houston, TX 77074	Date of Injury: Employer's Name: City of Houston Insurance Carrier's No.: 20784X1

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4-18-04	4-22-04	Inpatient Hospitalization	$34,466.00	$00.00
5-30-04	6-11-04	Inpatient Hospitalization	$31,458.81	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of April 15, 2005 states, "… Due to the patient's multiple injuries, infections and complications, his hospitalizations were both costly and extensive… Because the hospital's usual and customary charges exceeded the stop loss threshold, payment should have been made at 75% of total charges. The carrier has not demonstrated that Memorial Hermann Hospital's charges are not usual and customary in the location and under the circumstances in which they were provided…".

PART IV: RESPONDENT'S POSITION SUMMARY

A position statement was not submitted. However, the Respondent's rationale on the Table of Disputed Services states, "TPA accepts Concentra's determination".

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" for the admission on April 18, 2004 to April 22, 2004 and the admission on May 5, 2004 to June 11, 2004. The Requestor did not submit any medical documentation for either admission. The UB-92 for April 18, 2004 to April 22, 2004 admission list the "Prin Diag" code as "482.41", pneumonia due to staphylococcus aureus and the "Principal Procedure" as "38.93", venous catherization. The UB-92 for May 5, 2004 to June 11, 2004 admission list the "Prin Diag" code as "996.2", Mech comp nervous system device implant & graf and the "Principal Procedure" as "02.42", replacement of ventricular shunt. 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 the admission on April 18, 2004 to April 22, 2004 was 4 days (consisting of 3 days intensive care or ICU). Accordingly, the standard per diem amount due for this admission is equal to $1,118.00 (1 times $1,118) and $4,680.00 (3 times $1,560) for a total of $5,798.00. The Respondent paid $6,933.06. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit any medical documentation nor any invoices; therefore, MDR cannot determine the cost plus 10%.

The total length of stay for the admission on May 5, 2004 to June 11, 2004 was 12 days (consisting of 4 days intensive care or ICU).

Accordingly, the standard per diem amount due for this admission is equal to $8,944.00 (8 times $1,118) and $6,240.00 (4 times $1,560) for a total of $15,184.00. The Respondent paid $15,116.00. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit any medical documentation nor any 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 the admission on April 18, 2004 to April 22, 2004 and the admission on May 5, 2004 to June 11, 2004.

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:

Authorized Signature	Typed Name	Date of Decision
	Roy Lewis	6-9-05

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: _____