

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 Twelve Oaks Medical Center C/o Hollaway & Gumbert 3701 Kirby Drive, Suite 1288 Houston, TX 77098-3926		MDR Tracking No.: M4-05-6887-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address Transportation Ins. Co./Rep. Box #: 47 C/o Burns Anderson Jury & Brenner P.O. Box 26300 Austin, TX 78755-0300		Date of Injury:	
		Employer's Name: Skillmaster Staffing Services	
		Insurance Carrier's No.: 3C807841	

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4-30-04	5-1-04	Inpatient Hospitalization	\$27,598.61	\$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of May 23, 2005 states, "... 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 threshold of \$40,000 resulting in a reimbursement of \$32,307.01. Based on the clear working of the rules of the TWCC, the carrier is liable for an additional sum owed our client in the amount of \$27,598.61...".

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement was not submitted.

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." In particular, this admission resulted in a hospital stay of 1 day. The operative report of April 30, 2004 indicated the patient underwent "... Gilby compression L5, decompression L4-5, L5-S, bone graft harvesting right iliac crest, posterolateral L4-5 fusion, posterolateral L5-S1 fusion, segmental pedicle screw instrumentation L4-L5-S1, Nuvasive double electrode monitoring for pedicle screw hole preparation and insertion..." 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 1 day (consisting of 1 day for surgical). Accordingly, the standard per diem amount due for this admission is equal to \$1,118.00 (1 times \$1,118.00). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit 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 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

6-6-05

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, 7551 Metro Center Drive, Suite # 100, 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 en 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: _____