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, Texas 77098-3926	MDR Tracking No.: M4-05-6897-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Zurich Insurance Company P O Box 13367 Austin, Texas 78711-3367 Box 19	Date of Injury: Employer's Name: Leaman Building Materials, LP Insurance Carrier's No.: 2620054584

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/29/04	**05/04/04**	**Surgical Admission**	**$7,245.65**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

"As stated above, our client does not agree with the position of the insurance carrier and is seeking assistance form Medical Dispute Resolution in order to resolve this issue."

PART IV: RESPONDENT'S POSITION SUMMARY

"The Requestor asserts it is entitled to reimbursement in the amount of $58,979.75, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges."

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 additional 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 information provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." The requestor submitted an operative report indicating a posterior lumbar fusion at L5-S1 was performed. The patient was transferred to his bed in recovery in satisfactory condition and no complications were noted. 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 carrier made reimbursement for the 5-day stay in the amount of $58,979.75.

The requestor billed $35,703.00 for the implantables.

The requestor submitted invoices indicating the cost for the implantables were $28,542.00.

Therefore, reimbursement based on per diem is $5,590.00(5 x $1,118.00) and reimbursement for the implantables at cost plus ten percent is $31,396.20 ($28,542.00 x 110%). Per diem for the 5-day stay is $5,590.00 + $31,396.20 for the implantables = $36,986.20 total

reimbursement recommended. The carrier reimbursed the provider $58,979.75 for the 5-day stay and the implantables, leaving no additional reimbursement recommended.

Therefore, based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is not entitled to additional reimbursement.

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 reimbursement.

Ordered by:

	Michael Bucklin	08/02/05
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 and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____