# AMENDED MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

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|---|---|
| **Type of Requestor:** (x) HCP ( ) IE ( ) IC | **Response Timely Filed?** (x) Yes () No |
| Requestor's Name and Address<br>Harris Methodist HEB<br>3255 West Pioneer Parkway<br>Arlington, Texas 76013 | MDR Tracking No.: M5-05-2586-01<br>**Previously M5-05-1585-01**<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br>Liberty Mutual Fire Insurance Company<br>P O Box 40460<br>Houston, Texas 77240-0460<br>Box 28 | Date of Injury:<br>Employer's Name:<br>Insurance Carrier's No.: |

## PART II: SUMMARY OF DISPUTE AND FINDINGS

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 07/02/04 | 07/13/04 | Surgical Admission | $33,406.91 | $0.00 |
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## PART III: REQUESTOR'S POSITION SUMMARY

"Our client does not agree with the position of the insurance carrier and is seeking assistance from the Medical Dispute Resolution for the disposition of this fee reimbursement dispute in question."

## PART IV: RESPONDENT'S POSITION SUMMARY

"Based on this authority, carrier has correctly calculated the amount owed for these dates of service. The post-audit amount was well under the $40,000 stop-loss threshold. Therefore, the per diem calculation method applied to this case. No additional reimbursement is owed to the provider."

## PART V: AMENDED MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Medical Review Division's Findings and Decision of April 28, 2005, was issued in error and subsequently withdrawn by the Medical Review Division. The Original Findings and Decision, Appeal Letter and Withdrawal Notice are reflected in Exhibit 1.
This Amended Findings and Decision supercedes all previous decisions rendered in this matter.

The Medical Review Division rendered a Findings and Decision involving a Medical payment dispute. A decision was issued in favor of the Respondent.
The Findings and Decision incorrectly recommended additional reimbursement based on unusually extensive services raised by the Requestor, resulting in the issuance of this Notice of Withdrawal.

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 did not submit an operative report indicating what procedure was performed. Accordingly, the stop-loss method does not apply and reimbursement is to be based on per diem and carve out of implantables described in the same rule.
The EOB indicates that the services were only preauthorized for 5 days. The additional 6 days were not preauthorized. The requestor did not refute this in their position statement.

The carrier denied the implants with the denial of F-charge for this procedure exceeds the Health Facility fee schedule assigned by the Texas Workers Compensation Commission and U-This service was not authorized.

The provider did not submit any invoices indicating the amount billed for the implantables. Therefore, MDR cannot determine the charges of the implantables and no reimbursement is recommended for the implantables.

The carrier made reimbursement for the 5-day stay in the amount of $6,167.50. Based on a per diem reimbursement (5 day-stay x $1,118.00 = $5,590.00) plus $33.00 for prosthesis and $544.50 for implants.

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: AMENDED 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:**

| | | 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 Amended 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 Amended 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 Amended Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____