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 Harris Methodist Hospital 3255 Pioneer Parkway Arlington, Texas 76013	MDR Tracking No.: M4-05-0428-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address INDEMNITY INSURANCE CO OF NORTH AMERICA 3421 W WILLIAM CANNON DRIVE STE 131 PMB # 113 AUSTIN TX 787455022 Box 15	Date of Injury: Employer's Name: Insurance Carrier's No.: 90000022

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01-08-04	**01-16-04**	**Surgical Admission**	**$32,488.38**	**$12,528.95**

PART III: REQUESTOR'S POSITION SUMMARY

According to Commission Rule 134.401 Acute Care Inpatient Hospital Fee Guidelines this meets the stop-loss threshold of $40,000 134.401(c)(6)(A)(i) and should be processed according to the stop-loss reimbursement factor of 75% per 134.401(c)(6)(A)(iii) and audited charges are to be paid by the stop-loss factor of 75%.

PART IV: RESPONDENT'S POSITION SUMMARY

The issue in this case is in regards to Harris Methodist Hospital's entitlement to additional reimbursement for facility charges. The total amount billed was $74,475.46. The total amount in dispute is $32,488.38. The provider is arguing that we owe additional per the stop loss rule. The carrier's argument is that billing submitted does not comply with the stop loss rule. Since the stay does not fall under the stop loss rule, carrier is only required to make reimbursement per diem as required by Section 134.401(c)(1). Applying the per diem amount, the provider is entitled to $23,368.22. The carrier paid $23.,368.22, which is correct per the commission rules.

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). In this particular admission, the principle diagnosis code was 824.8 related to trauma care for a fracture of ankle, unspecified closed. Pursuant to Rule 134.401(c)(5), the reimbursement for the entire admission shall be paid at a fair and reasonable rate (neither the per diem method nor the stop loss method apply to this case).

Determining the "fair and reasonable" reimbursement can be difficult. In this case, it appears that neither the requestor nor the respondent have persuasively shown that their position represents the appropriate amount. Therefore, an alternate approach is needed to determine the reimbursement amount.

Based on data contained in the Commission's medical billing database for dates of service in 2004, trauma admissions were reimbursed, on average, at 48.2% of the total charges (total payments divided by total charges). Applying this same formula to this specific case appears to be a sound method to determine the appropriate fair and reasonable reimbursement.

Accordingly, the health care provider is entitled to a total reimbursement amount of $35,897.17. This was calculated by multiplying the total charges of $74,475.46 by 48.2%.

Since the carrier has previously paid $23,368.22, the health care provider is entitled to additional reimbursement in the amount of $12,528.95.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor **is** entitled to additional reimbursement in the amount of $12,528.95. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20 days of this Order.

Ordered by:

		04-08-05
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: _____