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 MHHS Hermann Hospital P O BOX 1866 Fort Worth, Texas 76101	MDR Tracking No.: M4-05-0631-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TML INTERGOVERNMENTAL RISK POOL 1821 RUTHERFORD LN STE 100 AUSTIN TX 787545163 Box 19	Date of Injury: Employer's Name: City of Rosenburg Insurance Carrier's No.: 900000932

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-23-03	**11-21-03**	**Surgical Admission**	**$163,680.68**	**$101,874.40**

PART III: REQUESTOR'S POSITION SUMMARY

Preauthorization not required for emergent admit.

PART IV: RESPONDENT'S POSITION SUMMARY

TML-IRP paid $7,521.63 of a inflated bill for $228,269.75, reduced by MAR to $171,202.31. This leaves $163,680.68 in dispute. This is a stop loss case.

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 959.7 related to trauma care of an injury, trunk, knee, leg, ankle, foot. 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 2003, trauma admissions were reimbursed, on average, at 51.8% 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 $109,396.03. This was calculated by multiplying the total audited charges of $211,189.25 by 51.8%.

Since the carrier previously paid $7,521.63, the health care provider is entitled to additional reimbursement in the amount of $101,874.40.

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 $101,874.40. 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:

	Bob Shipe	04-15-05
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: _____