

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 Valley Regional Medical Center C/o Hollaway & Gumbert 3701 Kirby Drive, Suite 1288 Houston, Texas 77098		MDR Tracking No.:	M4-05-1383-01
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address Texas Mutual Ins. Co./Rep. Box #: 54 P.O. Box 12029 Austin, Texas 78711-2029		Date of Injury:	
		Employer's Name:	Harlingen Glass & Mirror Co.
		Insurance Carrier's No.:	99D0000358808

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-22-03	10-30-03	Inpatient Hospitalization	\$7,034.39	\$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of November 12, 2004 states, "...It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines... Specifically on the dates October 22, 2003 through October 30, 2003... admission was inpatient, this claim would be reimbursed pursuant to TWCC Rule 134.401..."

PART IV: RESPONDENT'S POSITION SUMMARY

Position summary of November 1, 2004, states, "... It is this carrier's position that a fair and reasonable reimbursement has been made... This carrier reimbursed the requester 80.25% of the amount billed, this carrier's fair and reasonable reimbursement for a trauma stop loss bill. Additionally, this carrier reimbursed the requester this cost plus 10% based on the requester's invoice for implantables..."

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

This dispute relates to inpatient services provided in a 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 "OPEN REDUCTION, INTERNAL AND EXTERNAL FIXATION OF RIGHT DISTAL TIBIA, CLOSED REDUCTION AND EXTERNAL FIXATION OF LEFT TIBIA". Pursuant to Rule 134.401(c)(5), the reimbursement for the entire admission shall be paid at a fair and reasonable rate as 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 the 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 \$33,523.04. This was calculated by multiplying the total charges of \$64,716.30 by 51.8%.

Since the carrier has previously paid \$41,502.84, 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 additional reimbursement.

Decision by:

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 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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____