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 United Regional Medical Center P.O. Box 1866 Fort Worth, TX 76101-1866	MDR Tracking No.: M4-05-2071-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **Box 15** Ace American Insurance Company P.O. Box 4574 Houston, TX 77210	Date of Injury: Employer's Name: Halliburton Energy Services, Inc. Insurance Carrier's No.: C290C154330

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/09/2004	03/15/2004	Revenue Code 278, Implants	$18,953.00	$0.00
02/09/2004	03/15/2004	Revenue Code 272, Sterile Supply	$10,748.10	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The requestor asserts that the claim was paid incorrectly and additional payment is due for implants and sterile supply items. The requestor believes that the carrier owes 75% of billed charges under the Stop-loss method of reimbursement.

PART IV: RESPONDENT'S POSITION SUMMARY

The respondent asserts that this particular request pertains to unnecessary services and that the carrier properly reduced the charges based on a review conducted by a registered nurse and an orthopedic surgeon. The carrier believes that the claim was paid correctly.

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 952.06 related to trauma care for C5-C7 level with complete lesion of spinal cord. 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 applies to this particular admission).

Determining the "fair and reasonable" reimbursement can be difficult. 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 is one approach that can be considered sound and benchmark the expected reimbursement in the workers' compensation system. Under this methodology, the reimbursement due to the hospital would be $174,099.85, which is less than what the carrier paid for the entire admission. Another method would be to compare the reimbursement to the amount paid in the Medicare system (equal reimbursement would not be

entirely appropriate given the differences in the population). Reviewing the amount Medicare would pay appears to show that the carrier paid significantly more that that particular health care system's reimbursement methodology.

The insurance carrier has previously paid $241,201.02 for this particular admission. Considering the various alternate methodologies that could have been used compared with the reimbursement paid by the insurance carrier, we find that the "fair and reasonable" reimbursement for this admission is the amount paid by the insurance carrier.

Accordingly, we find that **no** additional reimbursement is due for these services.

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.

Findings and Decision by:

	Allen C. McDonald, Jr.	May 24, 2004
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 in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____