Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Insurance Carrier

Requestor=s Name and Address: Triumph Hospital of East Houston c/o Hollaway & Gumbert 3701 Kirby Drive, Suite 1288 Houston, TX 77098	MDR Tracking No.: M4-05-2741-01 Claim No.: Injured Employee's Name:
Respondent's Name and Box #: Connecticut Indemnity Co. Rep Box # 11	Date of Injury: Employer's Name: Assisted Living Concepts Inc. Insurance Carrier's No.: 790023879200

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC-60
2. Position Summary
3. UB-92
4. EOB's
5. Operative Report

Position Summary: Rules 134.401 (a) (4), 134.600 require this outpatient claim be paid at fair and reasonable rate; IC paid based on their determination of F & R without explaining their basis of determination in violation of TWCC Rule 133.304 (i); IC paid at standard surgical per diem rate for 2 days, failed to pay implants. HCP's charges are F & R based on services, supplies provided within the hospital setting, including the use of highly skilled personnel to deliver said services, supplies to claimant.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. Response to DWC-60
2. Reconsideration EOB showing additional amount due

Position Summary: Respondent did not submit a position summary.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12/11/03	Hospital Outpatient Services	I -III	$0.00

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

The request for medical dispute in this case was received on 12/10/04.

I. This dispute relates to hospital outpatient services provided in a hospital that are not covered under a Texas Department of Insurance, Division of Workers' Compensation ("TDI, DWC") fee guideline for this date of service. Therefore, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as described in 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d) to achieve, in part, access to quality medical care and effective medical cost control. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

II. The Requestor states "… in their position that HCP's charges are F & R based on services, supplies provided within the hospital setting including the use of highly skilled personnel to deliver said services supplies to claimant." The Respondent made payment on this date of service with reduction code "M- Allowance for this procedure was made at the "fair and reasonable" amount for this geographical area".

III. In this situation, the Requestor did not provide sufficient information on what a "fair and reasonable" reimbursement should be for these services. The Requestor purports that their total charges should be considered the amount for the "fair and reasonable" reimbursement. Hospital charges, however, are not a valid indicator of a hospital's costs at providing service nor at what is being paid by other payors. 22 *TexReg* 6269. In addition, Texas Labor Code section 413.011(d) provides, in part: "The [fee] guidelines may not provide for payment at a fee in excess of the fee… **paid** by that individual or by someone acting on that individual's behalf (emphasis added)." The Requestor has provided only charged amounts and not evidence of typical paid amount(s) for the disputed service(s).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

1) 28 Texas Administrative Code Sec. 134.1(d)
2) Other statutes, rules, and reference specified in this decision

PART VII: DIVISION FINDINGS AND DECISION

Based upon the lack of sufficient supporting documentation submitted by the Requestor and in accordance with the provisions of Texas Labor code, Sec. 413.031, the Division has determined that the Requestor **is not** entitled to additional reimbursement.

Decision by:

		10/27/06
Authorized Signature	Typed Name	Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of a medical dispute resolution, findings and decisions are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.