



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider () Insurance Carrier	
Requestor=s Name and Address: Vista Medical Center Hospital 4301 Vista Rd Pasadena TX 77504	MDR Tracking No.: M4-05-3534-01 Previously M4-05-2232-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Box #: ARGONAUT SOUTHWEST INSURANCE C Representative Box #17	Date of Injury:
	Employer's Name: GOWAN INC
	Insurance Carrier's No.: 40079228

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC-60
2. Letter requesting reconsideration
3. UB-92
4. EOB's
5. Operative Report

Position Summary: "...The Carrier denied charges utilizing code "M" when the Carrier did not make "fair and reasonable" reimbursement and did not make consistent reimbursements" ..."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC-60
2. Position statement
3. UB-92

Position Summary: "...The provider was reimbursed at the fair and reasonable rate that CovVel recommends...the carrier has complied with all rules and guidelines and additional reimbursement should not be recommended ..."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12/22/03	Hospital Outpatient Services	1, 2, 3	\$00.00
TOTAL			\$00.00

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

The request for medical dispute in this case was received on 11/23/04.

1. 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.
2. The Requestor stated in their position that "...The Carrier denied charges utilizing code "M" when the Carrier did not make "fair and reasonable" reimbursement and did not make consistent reimbursements ..." The reduction code of "M" (no MAR) is a valid reduction code for the dates of service in dispute.
3. 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:

James Schneider

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.