

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

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| Type of Requestor: (X) HCP () IE () IC | Response Timely Filed? (X) Yes () No |
| Requestor Twelve Oaks Medical Center c/o Hollaway & Gumbert 3701 Kirby Dr., Ste. 1288 Houston, TX 77098-3926 | MDR Tracking No.: M4-05-4767-01 |
| | TWCC No.: |
| | Injured Employee's Name: |
| Respondent Commerce & Industry Insurance Co. Rep. Box # 19 | Date of Injury: |
| | Employer's Name: Johnsrud Transport Inc. |
| | Insurance Carrier's No.: 077086962 |

PART II: SUMMARY OF DISPUTE AND FINDINGS

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|------------------|--------|----------------------------|-------------------|------------|
| From | To | | | |
| 3-1-04 | 3-7-04 | Inpatient Hospitalization | \$10,987.57 | \$0.00 |

PART III: REQUESTOR'S POSITION SUMMARY

IC failed to pay per TWCC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline and SOAH decision 453-04-3600.M4...Per TWCC Rule 134.401(c)(6)...claim pays @ 75% of total charges as charges exceed \$40,000.00 stop-loss threshold. Carrier further failed to audit according to TWCC Rule 134.401(C)(6)(A)(v).

PART IV: RESPONDENT'S POSITION SUMMARY

Requestor billed a total of \$107,203.65. The Requestor asserts it is entitled to reimbursement in the amount of \$73,970.52, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges.

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 839.20 related to trauma care for closed dislocation of the lumbar vertebra. Pursuant to Rule 134.401(c)(5), the reimbursement for the entire admission shall be paid at a fair and reasonable rate.

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 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 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 \$51,672.15. This was calculated by multiplying the total charges of \$107,203.65 by 48.2%.

The insurance carrier audited the bill and paid \$62,982.95 for the inpatient hospitalization.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount

previously paid by the insurance carrier, 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:

Elizabeth Pickle, RHIA

June 8, 2005

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: _____