

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 The Methodist Hospital P O Box 1866 Fort Worth, Texas 76101	MDR Tracking No.: M4-05-8183-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Casualty Company of Reading PA C/O Burns Anderson Jury & Brenner P O Box 26300 Austin, Texas 78755-0300 Box 47	Date of Injury:
	Employer's Name: Oreilly Automotive, Inc.
	Insurance Carrier's No.: 3C811467

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
06/09/04	06/16/04	Surgical Admission	\$28,504.99	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position statement.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not submit a position statement.

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 806.4 related to trauma care for a closed fracture lumbar spine with spinal cord injury. 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 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 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 not entitled additional reimbursement amount. This was calculated by multiplying the total charges of \$139,135.29 by 48.2% that equals \$67,063.21.

Since the carrier has previously paid \$68,889.71, 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.

Ordered by:

Michael Bucklin

08/09/05

Authorized Signature

Typed Name

Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution orders 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.

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 and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____