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 ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Memorial Hermann Hospital System 3200 S.W. Freeway, Suite 2200 Fort Worth, Texas 76191-6063	MDR Tracking No.: M4-05-A582-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company 6210 East Highway 290 Austin, Texas 78723-1098 Box 54	Date of Injury: Employer's Name: Rafael Lopez Insurance Carrier's No.: 99E0000385349

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted a position statement. Requestor states: "Due to the nature of the patient's injuries, he required unusually extensive services and supplies during his stay. The hospital billed its usual and customary charges in the total amount of $40,579.50. Due to the unusually extensive services and supplies provided for this patient's care and treatment, the hospital's usual and customary charges for ICU, room and board, ancillary services and drug charges should be paid at a fair and reasonable rate."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier submitted a position statement that supports their reason for no additional reimbursement. "It is the carrier's position that a fair and reasonable reimbursement for the dates of service in dispute was reimbursed. This carrier reimbursed the requester this carrier's fair and reasonable per diem reimbursement for a trauma in-patient ICU stay at $1,676 a day for 4 days and $968 for 2 days trauma medical inpatient stay."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due
07/21/04-08/02/04	Surgical Admission	I	$8,899.70

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

I. 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 852.06 related to trauma care for a subarachnoid hemorrhage from a fall; 861.21 contusion to lung from trauma; 865 injury to spleen and 860.4 traumatic pneumothorax. 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 entitled to an additional reimbursement amount of $8,899.70. This was calculated by multiplying the total charges of $40,579.50 by 48.2% = $19,559.37 - $10,659.67 already paid by the carrier = $8,899.70 in additional reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.401 (c)(5).

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor **is** entitled to additional reimbursement in the amount of $8,899.70. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

	Michael Bucklin	12/20/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. 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.