AMENDED MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Vista Medical Center 4301 Vista Road Pasadena, Texas 77503	MDR Tracking No.: M4-05-6932-01 **Previously M4-03-3666-01** TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance Company C/O Hanna & Plaut, LLP 106 East Sixth Street, Suite 600 Austin, Texas 78701 Box 28	Date of Injury: Employer's Name: Suntory International Corporation Insurance Carrier's No.: 949377450

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/01/02	**03/09/02**	**Surgical Admission**	**$38,289.79**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

"According to the literal interpretation of TWCC Rule 134.401 and the further clarification by the TWCC from QRL 01-03, a Carrier may not 'deduct' any carve-out costs listed in Rule 134.401(c)(4). Further, additional reimbursement for implants or any other 'carve-out costs' shall only be reimbursed at cost plus 10% if the stop-loss threshold is NOT met. Therefore, in this instance, the Carrier has severely under-reimbursed the billed charges, despite the clear language in the Texas Administrative Codes and further clarification by the TWCC in QRL 01-03."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely.

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

The Medical Review Division's Findings and Decision of September 27, 2004, was issued in error and subsequently withdrawn by the Medical Review Division. The Original Findings and Decision, Appeal Letter and Withdrawal Notice are reflected in Exhibit 1. This Amended Findings and Decision supercedes all previous decisions rendered in this matter.

The Medical Review Division rendered a Findings and Decision involving a Medical payment dispute. A decision was issued in favor of the Respondent.
The Findings and Decision incorrectly recommended reimbursement per the Usual and Customary issues raised by the Respondent, resulting in the issuance of this Notice of Withdrawal.

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). The hospital has requested additional reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the information provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem and carve out

methodology described in the same rule. The requestor indicates per the operative report that this was a posterior lumbar fusion L5-S1. Operative report also indicates that there were no complications and the patient was transferred to the recovery room in satisfactory condition.

The carrier made reimbursement for the 8-day stay in the amount of $80,266.77. The provider billed $83,300.00 for the implantables, but did not submit any invoices to determine the cost. Therefore, MDR cannot determine the cost of the implantables and no reimbursement is recommended for the implantables.

Therefore, based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is not entitled to additional reimbursement.

PART VI: AMENDED 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:

Authorized Signature	Typed Name	Date of Order
	Michael Bucklin	07/19/05

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 Amended Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Amended Decision is deemed received by you five days after it was mailed and the first working day after the date the Amended 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 Amended Decision should be attached to the request.

The party appealing the Division's Amended 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 Amended Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____