

AMENDED 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 HCA Spring Branch Medical Center C/O Hollaway & Gumbert 3701 Kirby Drive, Suite 1288 Houston, Texas 77098-3926	MDR Tracking No.: M4-05-8300-01 Previously M4-03-7840-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Zurich Insurance Company P O Box 13367 Austin, Texas 78711-3367 Box 19	Date of Injury:
	Employer's Name: Amber, Inc.
	Insurance Carrier's No.: 2620088682

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/05/02	09/10/02	Surgical Admission	\$14,135.56	\$14,135.56

PART III: REQUESTOR'S POSITION SUMMARY

"Our client does not agree with the position of the insurance carrier and is seeking assistance from the Medical Dispute Resolution for the disposition of this fee reimbursement dispute in question."

PART IV: RESPONDENT'S POSITION SUMMARY

"Based on this authority, carrier has correctly calculated the amount owed for these dates of service. The post-audit amount was well under the \$40,000 stop-loss threshold. Therefore, the per diem calculation method applied to this case. No additional reimbursement is owed to the provider."

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

The Medical Review Division's Findings and Decision of April 28, 2005, was issued in error and subsequently withdrawn by the Medical Review Division.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 no additional reimbursement based on unusually extensive services raised by the Requestor, 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 appear that this particular admission involved "unusually extensive services." The requestor indicates in the operative report, that this was an anterior and posterior lumbar fusion L5-S1. The patient was

transferred to the recovery room in satisfactory condition and no complications were noted in the operative report. Accordingly, the stop-loss method does apply and the reimbursement is to be based methodology described in the same rule.

The carrier made reimbursement for the 5-day stay in the amount of \$81,023.48. The provider billed the carrier \$108,031.30 for the 5 day-stay, leaving \$14,135.56 in dispute.

Using the stop-loss methodology the total allowable WCRA is \$108,031.30.

The carrier has reimbursed the provider \$66,887.92.

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 entitled to an additional reimbursement for these services equal to \$14,135.56; total allowable WCRA \$108,031.30 x 75% = \$81,023.48 - \$66,887.92 already paid = additional reimbursement of \$14,135.56. Therefore, additional reimbursement in the amount of \$51,170.28 is recommended.

PART VI: AMENDED COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$14,135.56. 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 20 days of this Order.

Ordered by:

Amy Rich

07/19/05

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 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 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: _____