



AMENDED 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: Vista Medical Center Hospital 4301 Vista Road Pasadena, Texas 77503	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">MDR Tracking No.:</td> <td style="width: 70%;">M4-05-A419-01 Previously M4-03-3827-01</td> </tr> <tr> <td>Claim No.:</td> <td></td> </tr> <tr> <td>Injured Employee's Name:</td> <td></td> </tr> </table>	MDR Tracking No.:	M4-05-A419-01 Previously M4-03-3827-01	Claim No.:		Injured Employee's Name:	
MDR Tracking No.:	M4-05-A419-01 Previously M4-03-3827-01						
Claim No.:							
Injured Employee's Name:							
Respondent's Name and Address: Zurich American Insurance Company P O Box 13367 Austin, Texas 78711-3367 Box 19	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Date of Injury:</td> <td style="width: 70%;"></td> </tr> <tr> <td>Employer's Name:</td> <td>KONE, Inc.</td> </tr> <tr> <td>Insurance Carrier's No.:</td> <td>93051359850434</td> </tr> </table>	Date of Injury:		Employer's Name:	KONE, Inc.	Insurance Carrier's No.:	93051359850434
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PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted, operative report, discharge summary and position statement. "In this instance, the audited charges that remained after the last bill review by the insurance carrier were \$235,063.06. There was no indication by the Carrier that any charges has been 'deducted' form the billed charges as a result of any personal items, lack of documentation, or items unrelated to the compensable injury. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of \$165,850.86, plus interest."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position statement found in the case file.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
04/30/02-05/07/02	Surgical Admission	I	\$0.00

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

I. The Medical Review Division's Findings and Decision of June 28 2005, was issued in error and subsequently withdrawn by the Medical Review Division.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 an incorrect injured worker. A decision was issued in favor of the Requestor.

The Findings and Decision incorrectly involved the wrong injured worker, 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 and anterior lumbar fusion L5-S1. Operative report also indicates that there were no complications and the patient was stable during the procedure.

The carrier made reimbursement for the implantables in the amount of \$2,392.50. The provider billed \$131,054.06 for two implantables listed on the UB-92, but did not submit any invoices to determine their cost. Therefore, MDR cannot determine the cost of the implantables and no additional 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: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.401 (c)(6).

PART VII: DIVISION AMENDED 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 not** entitled to additional reimbursement.

Ordered by:

Michael Bucklin

01/31/06

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of amended 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.