Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TEXAS 77504

Carrier's Austin Representative Box
Box 47

MFDR Date Received
JANUARY 15, 2003

Respondent Name
HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number
M4-03-2230

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 4, 2003: "if the total audited charges *for the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission."

Requestor's Supplemental Position Summary Dated February 15, 2013: "Please allow this letter to serve as a supplemental statement to Vista Medical Center Hospital's (VMCH) originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment. On this date of service, pre-authorized hospital inpatient services were provided to the compensable area to the above-referenced Claimant for an injury suffered during the course and scope of employment. According to the Third Court of Appeals' opinion, a provider is entitled to reimbursement under the 'Stop-Loss' exception in the Acute Care Inpatient Hospital Fee Guideline if the audited billed charges exceed $40,000 and if the surgery(ies) performed on the claimant were unusually extensive and unusually costly. T*exas Mutual Ins. Co. v. Vista Comm. Med. Ctr.,* 275 +S.W.3d 538 (Tex. App.-Austin 2008, pet. denied). When these elements are proven, then the provider is entitled to be paid 75% of billed charges."

Amount in Dispute: $86,078.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 12, 2004: "The Carrier has reimbursed the Provider in accordance with per diem guidelines which is applicable in this case. The implantables and CT Scan charges were deducted and thus made the billing less than $40,000 and applicable to the State Per Diem Guidelines. The charges for Implantables, CT Scan and other services were then reimbursed at fair and reasonable based on State Guidelines. Please see attached Rule 134.400."

Response Submitted by: The Hartford

Respondent's Supplemental Position Summary Dated October 25, 2004: "Please be advised that this firm has been retained to represent the interests of Hartford Casualty Insurance Company in the above-referenced matter."

Response Submitted by: Stone, Loughlin & Swanson, L.L.P.

Respondent's Supplemental Position Summary Dated December 14, 2012: "The inpatient hospital facility services provided by Vista Medical Center Hospital (Requestor) were not unusually costly and unusually extensive. Therefore, Requestor is not entitled to reimbursement under the stop-loss exception but should instead be reimbursed under the standard per diem reimbursement method…The medical records do not demonstrate that this was an outlier case. There is no evidence that Requestor provided services in this case that would not normally be provided to someone receiving the same type of surgery and that were unusually extensive and unusually costly. Furthermore, Requestor has not identified any specific services it contends were unusually extensive and it has not established the unusual cost of those services. In short, Requestor has not met its burden of proof. For these reasons, the Division should not approve reimbursement under the stop-loss exception but should affirm that reimbursement should be pursuant to the standard per diem method."

Response Submitted by: Stone, Loughlin & Swanson, L.L.P.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
January 14, 2002	Outpatient Hospital Services	$358.17	$0.00
January 24, 2002 through January 31, 2002	Inpatient Hospital Services	$85,720.57	$0.00
TOTAL		$86,078.74	$0.00

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6246, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. 28 Texas Administrative Code §133.301, 25 *Texas Register* 2115, effective July 15, 2000, addresses retrospective review of medical bills.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Hospital Outpatient Services Rendered on January 14, 2002:
   - H-Reimbursement is based upon half of the fee amount pending decision of audit or review.

   Hospital Inpatient Services Rendered on January 24, 2002 through January 31, 2002:
   - N-In order to review this charge we need a copy of the invoice detailing cost to the provider.
   - M-Reduced to Fair and Reasonable.

7. Dispute M4-03-2230 History
   - Dispute was originally decided on October 5, 2004.
   - The original dispute decision was appealed to the State Office of Administrative Hearings (SAOH).
   - SOAH issued a decision on October 12, 2007.
   - The SOAH decision was appealed to District Court under case number D-1-GN-07-003915.

- The 126th Judicial District remanded the dispute to the Division pursuant to an agreed order of remand dated December 1, 2011.
- As a result of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.
- Medical fee dispute issued a decision under re-docketed dispute number M4-03-2230-02 on December 28, 2012.
- M4-03-2230-02 was withdrawn by the Division on January 18, 2013 and was re-docketed under M4-03-2230-03.
- M4-03-2230-03 is hereby reviewed.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for outpatient services rendered on January 14, 2002?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this dispute supplemented the original MDR submissions. The division received supplemental positions as noted above. Positions were exchanged among the parties as appropriate. Documentation filed by the requestor and respondent to date is considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold…" In that same opinion, the Third Court of Appeals states that the stop loss exception "…was meant to apply on a case-by-case basis in relatively few cases." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §133.307(d) (1) states "Timeliness. A person or entity who fails to timely file a request waives the right to medical dispute resolution. The commission shall deem a request to be filed on the date the division receives the request, and timeliness shall be determined as follows: (1) A request for medical dispute resolution on a carrier denial or reduction of a medical bill pursuant to §133.304 of this title (relating to Medical Payments and Denials) or an employee reimbursement request shall be considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute." The date of the services in dispute is January 14, 2002. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on January 15, 2003. This date is later than one year after the date(s) of service in dispute. The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, 28 Texas Administrative Code §134.401(c)(6)(A)(v) states that "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." Review of the explanation of benefits issued by the respondent finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $150,784.09. The Division concludes that the total audited charges exceed $40,000.

3. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services" and further states that "independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." In its position, the requestor states:

   > This complex spine surgery is unusually extensive for at least three reasons: first, this surgery as noted above required extensive spinal instrumentation, a cell saver was required and this patient required the insertion of an epidural catheter instead of the typical PCA pump to manage pain, which is not usual for these types of procedures; second, Medicare's length of stay for this DRG is 5.4 days and the median length of stay for workers' compensation inpatient admissions is three days, whereas the length of stay for this admission was 11 days, exceeds both the Medicare LOS and the median LOS for workers' compensation; and third, the patient post-operatively developed several complications including: chest discomfort and tachycardia which required a V/Q scan to rule out a pulmonary embolism. This patient had developed a pulmonary embolism which is atypical and required aggressive treatment including daily testing of the coagulation factors. Due to the atypical chest pain and subsequent pulmonary embolism, telemetry monitoring was required and an extended length of stay, which are unusually extensive in these types of cases as they are deviations from the norm. This patient also had issues with pain control and developed a fever post-operatively.

   The requestor discusses some case-specific medical factors in support of its contention that the disputed services are unusually extensive; however, the requestor fails to discuss or demonstrate how these factors may be considered unusually extensive when compared to similar spinal surgeries, services, or admissions. Furthermore, the requestor has not provided information or documentation to support the basis for its conclusion of a median length of stay for workers' compensation inpatient admissions as being three days. The Requestor does not specify whether any such data concerned Texas hospitals and addressed services in the year 2002 when the services in this matter were provided. No additional information was found to substantiate why this surgical operation involved unusually extensive services compared with similar operations; therefore, the division finds that the requestor did not meet the requirements of 28 Tex. Admin. Code § 134.401 (c)(6)(A)(ii).

4. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The Third Court of Appeals' November 13, 2008 opinion affirmed that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. The court further held that "What is unusually costly and unusually extensive in any particular fee dispute remains a fact-intensive inquiry best left to the Division's determination on a case-by-case basis…The scope of this authority includes the discretion to determine whether those standards have been met." The Division hereby examines the information and documentation available for the purpose of determining whether the requestor sufficiently supports that the services is dispute were unusually costly.

   In its position, the requestor contends that "The medical and billing records on file with MDR and additional records attached hereto, also show that this admission was unusually costly for three reasons: first, the Medicare outlier threshold amount for this DRG was $109,922.29. Our charges were $157,119.94 for this case. Therefore, this would qualify for additional reimbursement above the DRG reimbursements; and second, it was necessary to purchase expensive implants for use in the surgery; and third, additional and extensive resources were utilized to manage the patient post-operatively."

   The requestor relies upon Medicare's outlier threshold policy as its method to establish that the admission in dispute is unusually costly. The Medicare policy that the requestor relies on may be found at Section 1886(d)(5)(A) of the Federal Social Security Act and in the *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 3 found at www.cms.gov. According to this policy, admissions for which a hospital incurs extraordinarily high costs may qualify for payments in addition to the basic Inpatient Prospective Payment System (IPPS) payment. In order to qualify for a so-called "outlier payment" the cost to the hospital for a specific admission must exceed a fixed cost outlier threshold amount. Factors which affect the calculation of the fixed cost outlier threshold amount may change and are updated annually as part of the Inpatient Prospective Payment System (IPPS) final rule, or when relevant, final rules are implemented in Medicare.

   In its attempt to support its position that the service in dispute would have qualified for a Medicare outlier payment, the Division finds that:

- the requestor misapplies Medicare's outlier policy by comparing its alleged outlier threshold amount to its total **billed** charges, rather than the **costs to the hospital** for the admission in dispute;
- the requestor overlooks the fact that within the Texas Labor Code, total billed charges are not a valid indicator of cost as explained in the preamble to 28 Texas Administrative Code §134.401, 22 *Texas Register* 6246, effective August 1, 1997.
- the requestor fails to calculate or reasonably estimate the total costs to the hospital for the services in dispute;
- the requestor fails to demonstrate how it arrived at its alleged outlier threshold amount of $109,922.29; and
- the requestor did not demonstrate that factors used to determine its outlier threshold were appropriate for the dates of service involved in the admission.

Although the requestor adds that the costs to the hospital were "increased" due to the purchase expensive implants for use in the surgery, the use a cell saver and epidural catheter, and treatment for a pulmonary embolism the requestor fails to discuss or demonstrate how these costs were unusual when compared to similar surgeries or admissions. For all the reason stated, the Division concludes that the requestor has failed to support that the service in dispute were unusually costly.

5. For the reasons stated above, the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) subtitled *Standard Per Diem Amount* and §134.401(c)(4) subtitled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission." Review of the submitted documentation finds that the length of stay for this admission was eight surgical days, all of which were preauthorized by the workers' compensation insurance carrier; therefore, the standard per diem amount of $1,118.00 applies. The per diem rate multiplied by the length of stay results in a total allowable amount of $8,944.00.

   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
   - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $70,960.00.
   - Review of the medical documentation provided finds that although the requestor billed items under revenue code 278, no invoices were found to support the cost of the implantables billed. For that reason, no additional reimbursement can be recommended.
   - 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $260.00 for revenue code 391-Blood Administration. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
   - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $425.00/unit for Epidural 0.1% 250ml. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, additional reimbursement for these items cannot be recommended

   The division concludes that the total allowable reimbursement for this admission is the SPDA of $8,944.00. The respondent issued payment in the amount of $27,367.50. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		1/9/2014
Signature	Medical Fee Dispute Resolution Officer	Date
		1/9/2014
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.