TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
VISTA MEDICAL CENTER HOSPITAL

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-03-7664

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 3, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier did not provide a proper explanation in conjunction with the 'F, N' payment exception code as required by the TWCC Rules and Commission instructions. Therefore, the Carrier has made no legal denial of reimbursement under the applicable rules and statutes…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 October 28, 2015: "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… The medical records on file with MDR show this admission to be a complex lumbar fusion. This complex spine surgery which is unusually extensive for the following reasons…The medical and billing records on file with MDR also show that this admission was unusually costly for the following reasons."

Amount in Dispute: $49,604.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on this authority, Self-insured 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."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
July 11, 2002 through July 19, 2002	Inpatient Hospital Services	$49,604.46	$0.00

FINDINGS AND DECISION

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 §133.304(c), 17 Texas Register 1105, effective February 20, 1992, sets out the provisions for insurance carrier's to dispute and audit medical bills.
3. 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.
4. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable Division fee guideline.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F-Reduction according to fee guidelines.
   - N-Not appropriately documented.
   - U-Unnecessary treatment (w/o peer review).
   - G-Include in global.
7. Dispute M4-03-7664 History
   - Dispute was originally decided on July 12, 2005.
   - The original dispute decision was appealed to District Court.
   - The 345th Judicial District remanded the dispute to the Division pursuant to an agreed order of remand dated July 10, 2015.
   - As a result of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.
   - M4-03-7664-02 is hereby reviewed.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
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. Does a medical necessity issue exist in this dispute?
6. 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 were given an opportunity to supplement the original MDR submissions after the 3rd Court of Appeals Decision. Only the requestor submitted a supplemental position as noted above. This Position was 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. The requestor in its position statement asserts that, "The Carrier did not provide a proper explanation in conjunction with the 'F, N' payment exception codes as required by the TWCC Rules and Commission instructions. Therefore, the Carrier has made no legal denial of reimbursement under the applicable rules and statutes." 28 Texas Administrative Code §133.304(c), 17 Texas Register 1105, effective February 20, 1992, applicable to dates of service in dispute, states, in pertinent part, that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." Review of the submitted documentation finds that the explanation of benefits were issued using the Division-approved form TWCC 62 and noted payment exception codes "F, Gand N."

   This payment exception code and description support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has substantially met the requirements of 28 Texas Administrative Code §133.304(c).

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 $118,593.53. The Division concludes that the total audited charges exceed $40,000.00.

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:

   > The medical records on file with MDR show this admission to be a complex lumbar fusion. This complex spine surgery is unusually extensive for at least the following reasons: This type of surgery is unusually extensive when compared to all workers' compensation admissions between 2001 and 2008 which totaled 68,775, which is based on data received from DWC through a Deposition on Written Questions. It is unusually extensive in that only 9% of the total admissions were for a lumbar spine fusion with a principle procedure code of 81.08 such as the surgery performed in this case; This type of surgery required a physician for neuromonitoring, a cell saver, additional trained nursing staff and specialized

equipment thereby making the hospital services unusually extensive; This procedure has a Medicare Severity Diagnostic Related Group (MS-DRG) of 498 which has a relative weight of 2.3026. This relative weight is 75% higher than the average relative weight of all DRG's for fiscal year 2002, the date this procedure was performed, and is 75% higher than all Major Diagnostic Category (MDC) 08 DRG's for the same fiscal year; This product has a relative weight that is 68% higher than the average Case Mix Index (CMI) for similar hospitals in Harris County where this procedure was performed; This procedure qualifies for outlier payments under Medicare making this an unusually extensive and unusually costly procedure and; Medicare length of stay for this DRG is 3.9 days whereas the length of stay for this admission of 8 days exceeds the average Medicare LOS.

The Division considered the requestor's position summaries regarding the unusually extensive services involved in this hospital admission, and if it qualifies for stop-loss reimbursement per 28 Texas Administrative Code §134.401(c)(6). Per the Third Court of Appeals' November 13, 2008, decision "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." 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." The Division reviewed the requestor's position summary and submitted documentation and finds the following:

- The requestor indicated that because 9% of the total a workers' compensation admissions between 2001 and 2008 involved lumbar spine fusions, this admission involved unusually extensive services. The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive. The Third Court of Appeal's decision noted that stop-loss reimbursement is meant to apply on a case-by-case basis. The requestor did not submit case specific information to support how the services in dispute were unusually extensive in relation to similar admissions.
- The requestor noted that the hospital admission required additional staff and specialized equipment thereby making the hospital services unusually extensive. A review of the submitted documentation finds that the requestor did not support that additional staff and specialized equipment were needed in comparison to similar surgeries.
- The requestor uses Medicare's MS-DRG and relative weights to support their argument that the disputed services involved an unusually extensive hospital stay. The Centers for Medicare & Medicaid Services (CMS) began using a new diagnosis-related groups (DRG) system called Medicare Severity (MS) on October 1, 2007; therefore, the requestor's argument is based on a system that did not exist on the disputed date of service.
- The requestor also noted that the admission was unusually extensive because the procedure's relative weight is 68% higher in comparison to the average CMI for similar hospitals in Harris County. The Division reviewed the submitted documentation and finds no documentation to support the requestor's position regarding the study to support its position.
- The requestor relies upon Medicare's outlier threshold policy as its method to establish that the admission in dispute is unusually extensive. 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. The requestor attempts to support its position that the services in dispute are unusually extensive by presuming that the admission in dispute would have qualified for a Medicare outlier payment; however, the requestor failed to present the factors and the calculation method to support its contention. The presumption that the service in dispute would have qualified for an outlier payment at the time the services were rendered is therefore unsupported.

- The requestor has not provided information or documentation to support the basis for its conclusion that the average Medicare length of stay is 3.9 days, or that this length of stay was appropriate for the dates of service involved in this particular admission.

For the reasons stated, the Division finds that the requestor has not demonstrated nor supported their position that the services in dispute involved unusually extensive services in relation to similar admissions.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 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 requestor's supplemental position statement asserts that:

   > The medical and billing records on file with MDR also show that this admission was unusually costly for at least the following reasons: The median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; As mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment such as large bore IV's and an arterial line and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries and; It was necessary to purchase expensive implants for use in the surgery.

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the Division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for similar spinal surgery services or admissions. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to similar spinal surgery services or admissions.

5. Per the explanation of benefits, the respondent initially denied reimbursement for services related to the inpatient hospitalization based upon reason code "U-Unnecessary treatment (w/o peer review), upon reconsideration, this denial reason was not maintained. The Division finds that a medical necessity issue does not exist in this dispute.

6. 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.

- Division rule at 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 (8) surgical days; therefore, the standard per diem amounts of $1,118.00 multiplied by the 8 days result 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 $64,590.00.
- 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)(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 $289.00/unit for Dilaudid PCA 100ml, and $265.35/unit for Thrombin 10,000 unit. 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 for this admission is $8,944.00. The respondent issued payment in the amount of $36,609.44. Based upon the documentation submitted, no additional reimbursement can be 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 reimbursement for the disputed services.

Authorized Signature

		02/02/2016
Signature	Medical Fee Dispute Resolution Officer	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 MFDR 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 this *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.