TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Vista Medical Center Hospital

Respondent Name
ACE American Insurance Co.

MFDR Tracking Number
M4-04-4912-02

Carrier's Austin Representative
Box Number 15

DWC Date Received
January 5, 2004

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 10, 2003 – January 14, 2003	Inpatient Hospital Services	$18,583.50	$0.00

Requestor's Position

Requestor's Original Position Summary Dated January 5, 2003: "Carrier used payment exception codes F-N-D- for as denial and reduction of payment for charges submitted. Healthcare provider is unable to determine what charges these codes have been applied to. F-Payment not in accordance with Acute In-Patient Stop Loss per Fee gideline. N-Carrier did not forward an explanation of missing documentation within 14 days of receipt of medical bill in compliance with Texas Administrative Code. All required TWCC documentation has been submitted to Carrier. D-Carrier utilized this code for charges not previously submitted for review."

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 is unusually extensive … The medical and billing records on file with MDR also show that this admission was unusually costly …"

Amount in Dispute: $18,583.50

Respondent's Position

Respondent's Position Summary Dated January 21, 2004: "The carrier's reimbursement complies with the reimbursements of section 413.011(b) of the Texas Labor Code and Compensation rules and is fair and reasonable."

Respondent's Supplemental Position Summary Dated February 13, 2004: "Vista medical center hospital has failed to meet its burden of proof to establish that its charges and the reimbursement it seeks is 'fair and reasonable', and comply with Rule 413.011(b) of the Texas Labor Code and commission rules. Regardless of the providers usual and customary charges, the carrier is required to pay 'fair and reasonable' per the Texas Labor Code and commission rules."

Respondent's Supplemental Position Summary Dated March 8, 2016: "The Requestor believes the reasonable resolution of these issues, and the one compelled by the Labor Code, Division rules and policies, and the Third Court of Appeals opinions, is to find the post SOAH *en banc* decision refund issue is not ripe for determination, and reserve the issue of the carriers' right to a refund until after a final determination has been made of the amount due for each hospital admission. Dispute resolution or compliance actions by the Division would be initiated upon request or upon notification of any failure to refund as circumstances require."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305, 27 Texas Register 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical disputes.

2. 28 TAC §133.304, 17 Texas Register 1105, effective February 20, 1992, sets out the provisions for insurance carriers to dispute and audit medical bills.

3. 28 TAC §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.

4. 28 TAC §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. 28 TAC §134.401, 22 Texas Register 6246, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 907 – N-Not appropriately documented/Texas required bill identification.
- 500 – N-Not appropriately documented/Additional report/documentation is needed to substantiate medical necessity of services rendered for inpatient bills.
- 640 – Nurse Review: Inpatient Hospital/Facility Bill.
- 329 – D-Duplicate bill/reimbursement not recommended as this charge appears to be a duplicate billing.
- 770 – U-Unnecessary treatment/personal items not covered.
- 999 – F-Fee Guideline/Reviewed charges.

Dispute History

- This dispute was originally decided on April 25, 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 D-1-GN-08-002549 dated July 10, 2015.
- As a result of the remand order, the dispute was re-docketed at the DWC's medical fee dispute resolution section.
- M4-04-4912-02 is hereby reviewed.

Issues

1. Did the audited charges exceed $40,000.00?

2. Did the admission in dispute involve unusually costly services?

3. Did the admission in dispute involve unusually extensive services?

4. Is the requestor entitled to additional reimbursement?

5. Is a refund claim presented for adjudication?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §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, (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 TAC §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." Subsequent decisions concerning this issue include the State Office of Administrative Hearings (SOAH) decision under docket 454-12-1961.M4 *Vista Medical Center*

Hospital, v. Carriers issued June 24, 2019, and the Third Court of Appeals December 28, 2022 opinion in *Vista Community Medical Center, LLP, v. Carriers.* These decisions concurred with the Third Court of Appeals' November 13, 2008 opinion on eligibility for reimbursement under the Stop-Loss Exception which required that total audited charges exceed $40,000 and that an admission involve unusually costly and unusually extensive services.

The requestor and respondent in this dispute were given an opportunity to supplement the original MDR submissions after the 3rd Court of Appeals Decision. Both parties submitted a supplemental position as noted above. These 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, which the SOAH decision and order 454-12-1961.M4 issued June 24, 2019, and the Third Court of Appeals December 28, 2022 opinion concurred, the DWC will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually costly; and whether the admission and disputed services ***in this case*** are unusually extensive. 28 TAC §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…" The opinion of 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 TAC §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 TAC §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 TAC §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 deducted $34.00 of personal charges in accordance with §134.401(c)(6)(A)(v); therefore, the audited charges equal $92,266.39. The DWC concludes that the total audited charges exceed $40,000.00.

2. 28 TAC §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 three opinions noted above 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.

   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 DWC notes that audited charges are addressed as a separate and distinct factor described in 28 TAC §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relationship has been established in this dispute. 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 DWC rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed and 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.

3. 28 TAC §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." It further states that "independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." As noted above, the 2019 SOAH opinion and the 2022 Third Court of Appeals opinion concurred with these findings.

   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 2.4738. This relative weight is 66% higher than the average relative weight of all DRG's for fiscal year 2003, the date this procedure was performed, and is 90% higher than all Major Diagnostic Category (MDC) 08 DRG's for the same fiscal year;

- This procedure has a relative weight that is 78% higher than the average Case Mix Index (CMI) for similar hospitals in Harris County where this procedure was performed and;

- Medicare length of stay for this DRG is 3.7 days whereas the length of stay for this admission of 4 days exceeds the average Medicare LOS."

The DWC considered the requestor's position summaries regarding the unusually extensive services involved in this hospital admission to determine if it qualifies for stop-loss reimbursement in accordance with 28 TAC §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 DWC 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 DWC 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. 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 TAC §134.401(c)(1) subtitled *Standard Per Diem Amount* and §134.401(c)(4) subtitled *Additional Reimbursements*. The DWC 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 TAC §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 four surgical days; therefore, the standard per diem amounts of $1,118.00 multiplied by the four days result in a total allowable amount of $4,472.00.

   28 TAC §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 $33,518.00. In its review of the documentation provided, the DWC finds that the invoice provided by the requestor was dated after the date of services and is therefore not representative of the cost of the implantables claimed in this request. The DWC finds that the documentation is insufficient to support the cost of the implantables billed. Therefore, no additional reimbursement can be recommended for these charges.

   Billed services include revenue code 391 for $299.00. Per 134.401(c)(4)(B)(iv), revenue codes 380-399 shall be reimbursed at a fair and reasonable rate. 28 TAC §134.1(c) states, in relevant part, "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011." The requestor submitted no evidence to support a fair and reasonable rate for these charges. Therefore, no reimbursement is recommended.

   The DWC finds that the total allowable for this admission is $4,472.00. According to the submitted documentation, the respondent issued payment in the amount of $50,641.79. The DWC finds that additional reimbursement cannot be recommended.

5. Per the foregoing analysis, the respondent insurance carrier has issued payment that exceeds the total allowable for this admission. In its supplemental response to this medical fee dispute, the insurance carrier does not advance a claim for refund, rather it simply states its position that submission of a refund claim and the DWC's adjudication of such a claim would be premature and that it "reserves the right" to advance such a claim. The respondent requests that the DWC "not claim subject matter jurisdiction" and, relatedly, "clarify (its position) related to refunds."

   The DWC's medical fee dispute resolution process involves a case-by-case determination of fee disputes presented. This process neither allows for nor requires consideration of, or response to, any parties' request that the DWC generally state its position as to a potential claim, however related to a pending dispute, that may or may not be asserted in the future.

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 TAC §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 DWC has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 19, 2023
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.