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
Memorial Herman Southwest Hospital

Respondent Name
Insurance Co. of the State of PA

MFDR Tracking Number
M4-05-2708-02

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 09, 2004

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 9, 2003 - December 25, 2003	Inpatient Hospital Services	$60,940.50	$0.00

Requestor's Position

Requestor's Position Summary: "Services were medically necessary & exceeded Stop Loss threshold."

Requestor's Supplemental Position Summary Dated December 8, 2004: "It is the hospital's position that the hospitalization and surgery were in fact medically necessary and the charges exceeded thr stop-loss threshold for reimbursement at 75% of billed charges. The billed charges were $81,254.00. The hospital received an underpayment of $17,888.00, leaving an outstanding balance due of $43,052.50."

Requestor's Supplemental Position Summary Dated January 10, 2005: "Contrary to the Carrier's Position of December 27, 2004, Rule 134.401, Stop Loss Reimbursement Rule does not include, by definition, that the stop loss methodology may be allowed, but only if the $40,000 threshold of audited charges is exceeded and then on 'on a case-by-case' basis. In fact, nowhere in the rule does it state that reimbursement will be based on 'on a case-by-case basis.' Further, the Commission's rules require hospitals to bill their usual and customary charges and provide

that all hospital charges are subject to audit … Therefore, the Carrier audit must show that the hospital's bill for audited charges exceeds its usual and customary charges or that the hospital's bill was not fair or reasonable. The Carrier has failed to show that the audited charges exceed the hospital's usual and customary charges or is not fair or reasonable."

Requestor's Supplemental Position Statement Dated April 12, 2005: "… the hospital's records reflect the patient was emergently admitted as identified on its UB92 with ICD-9 codes, reflecting trauma, and under the TWCC Acute Fee guideline, reimbursement to be at the hospital's usual and customary charges."

Amount in Dispute: $60,940.50

Respondent's Position

Respondent's Position Summary Dated December 27, 2004: "Requestor billed a total of $81,254.00. The requestor asserts it is entitled to reimbursement in the amount of $60,940.50, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges …

"Here, the initial $40,000 threshold of 'audited charges' may have been exceeded, but Requestor has not proven entitlement to any exception to the preferred per diem method. Such proof requires Requestor to show the services provided were unusually extensive and unusually costly for the subject admission."

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:

- F – reduction according to fee guidelines.
- The amount allowed may reflect an adjustment due to repricing to applicable state fee schedules and/or exclusions of patient convenience items.
- D – duplicate charge.
- M – reduced to fair and reasonable.
- N – not appropriately documented.
- The amount payable may reflect a comprehensive or per-diem adjustment due to repricing according to your contractual agreement with a preferred provider organization. This organization is not network application.
- G – Include in global.

Dispute History

- This dispute was originally decided on June 24, 2005.
- The original dispute decision was appealed to District Court.
- The 250th Judicial District remanded the dispute to the division pursuant to an agreed order of remand D-1-GN-08-002134 dated September 1, 2020.
- As a result of the remand order, the dispute was re-docketed at the DWC's medical fee dispute resolution section.
- M4-05-2708-02 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?

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.

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 did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore, the audited charges equal $81,254.00. 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 position statement does not address how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar spinal surgery services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The DWC concludes that the requestor failed to meet the requirements of 28 TAC §134.401(c)(6).

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 costly and 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."

The requestor's position statement does not address how this inpatient admission was unusually extensive. The requestor does not provide a reasonable comparison between the services associated with this admission when compared to similar spinal surgery services or admissions, thereby failing to demonstrate that the admission in dispute was unusually extensive. The DWC concludes that the requestor failed to meet the requirements of 28 TAC §134.401(c)(2)(C).

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)(1) provides standard per diem amounts, stating, "The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical--$870; Surgical--$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU)--$1,560."

   28 TAC §134.401(c)(3)(A) states, in pertinent part, "(ii)The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission. (iii) If applicable, ICU/CCU days are subtracted from the total LOS and reimbursed the ICU/CCU per diem rate for those specific days of treatment in lieu of the assigned medical/surgical per diem rate."

   The review of the submitted documentation finds that the request for medical fee dispute indicates that the dates of service were December 9-25, 2003. However, a review of the itemized record finds that the injured employee was admitted to the hospital on December 9, 2003, and was discharged on December 24, 2003. The length of stay, therefore, is 15 days. The admission included surgery/bronchoscopy. Documentation indicates that the injured employee was in ICU on December 12-14, 2003. Per 28 TAC §134.401(c)(3)(A)(iii), "ICU/CCU days are subtracted from the total LOS and reimbursed the ICU/CCU per diem rate for those specific days of treatment in lieu of the assigned medical/surgical per diem rate."

   The standard per diem amount of $1,118.00 is multiplied by the 13 surgical days, resulting in a total allowable amount of $14,534.00. The two ICU days are multiplied by the per diem amount of $1,560.00, resulting in a total allowable amount of $3,120.00. The total allowable reimbursement under the per diem method is $17,654.00.

   Billed services include revenue codes 350 for $7,560.50 and 610 for $2,482.25. Per 134.401(c)(4)(B), revenue codes 350 and 610 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 $17,654.00. According to the submitted documentation, the respondent issued payment in the amount of $17,888.00. The DWC finds that 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 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

Signature	Medical Fee Dispute Resolution Officer	October 31, 2023 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.