Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
VISTA MEDICAL CENTER HOSPITAL

Respondent Name
ASSOCIATION CASUALTY INSURANCE CO

MFDR Tracking Number
M4-05-3302-02

Carrier's Austin Representative
Box Number 53

MFDR Date Received
JANUARY 10, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "if the total audited charges *for the entire admission* are below $40,000, the Carrier may reimburse at a 'per diem' rate for the hospital services. However, 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 September 9, 2014: "Please allow this letter to serve as a supplemental statement to Vista Medical Center Hospitals' (VMCH) originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment."

Amount in Dispute: $43,094.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated January 27, 2005: "Based on the available information in file and the results of the audited charges and methodology described above, it is our professional opinion that the adjusted amount of $41,513.91 then subject to reimbursement per Texas Workers' Compensation Adopted Rules was at a fair and reasonable rate."
Response Submitted by: Corvel

Respondent's Supplemental Position Summary Dated September 11, 2014: "Because Requestor has not met its burden of demonstrating its services were unusually extensive and unusually costly, and the documentation adduced this far fails to provide any rationale for the Requestor's qualification for payment under the Stop-Loss Exception, no additional monies are due to the Requestor."

Response Submitted by: Hanna & Plaut L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2004 through January 18, 2004	Inpatient Hospital Services	$43,094.00	$1,016.00

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, sets out the procedures for medical payments and denials.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, 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 provides for fair and reasonable reimbursement of health care in the absence of an applicable 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-Fee Guideline MAR Reduction.
   - M-No MAR.
   - N-Not Documented.
   - R-Extent of Injury
   - A-Pre-authorization Required/Not Requested.
   - 304-Submit Supply House Invoice for additional payment.
   - 520-Inpatient Surgical Per Diem Allowance.
   - 831-MedCheck Select Adjustment Amount.
   - 527-Recommended at 100% of invoice price.

Issues

1. Does a compensability/related issue exist in this dispute?
2. Did the respondent provide sufficient explanation for denial of the disputed services?
3. Did the audited charges exceed $40,000.00?
4. Did the admission in dispute involve unusually extensive services?
5. Did the admission in dispute involve unusually costly services?
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 case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be 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 as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The Division originally issued a Findings and Decision under Tracking number M4-03-3302-01 on May 20, 2005. The original dispute decision was appealed to the State Office of Administrative Hearings (SOAH). SOAH issued Order No. 15 on February 22, 2011 remanding the dispute to the Division until the DWC 24/BRC issue has been resolved. Because of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.

   To comply with the SOAH remand order, medical fee dispute resolution re-docketed the dispute. M4-05-3302-02 is hereby reviewed.

   According to the remand order, a compensability/related issue exists in this dispute.

   28 Texas Administrative Code §133.304(f)(3) states "The insurance carrier shall send a copy of the explanation of benefits to the injured employee at the same time it is sent to the sender of the bill if the insurance carrier has reduced or denied payment for a charge on the bill because the insurance carrier believes that treatment(s) and/or service(s) were: (3) unrelated to the compensable injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements)." A review of the explanation of benefits finds that the respondent did not deny payment for the disputed services based upon compensability or unrelated issues; therefore, the Division concludes that a compensability or unrelated issue does not exist in this dispute.

   The issue in this dispute is whether the requestor is due additional reimbursement for the disputed services. 28 Texas Administrative Code §133.307(a) states "In resolving disputes over the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury." Therefore, per 28 Texas Administrative Code §133.307, medical fee dispute resolution maintains jurisdiction to review the disputed services.

2. The requestor in its position statement asserts that "Texas Administrative Code Section 133.304 specifically provides the 'explanation of benefits **shall include the correct payment exception codes**'." 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."

   The payment exception codes and descriptions listed above in the background section support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401, and were provided using the appropriate division-approved form TWCC 62. 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).

3. 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, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits finds that the carrier deducted $19.20 in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $65,125.84. The Division concludes that the total audited charges exceed $40,000.

4. The requestor in its original position statement asserts that "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'." As noted above, 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) rendered judgment to the contrary. The requestor's original assertion is not supported.

   In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, 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 extensive services. Rule

§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 requestor's supplemental position statement asserts that:

> The medical records on file with MDR show this admission to be a complex ankle refusion with removal of prior hardware due to a nonunion.This complex surgery is unusually extensive for at least the following reasons:
> - This patient required IV antibiotics for several days due to previous infection in the surgical area requiring a longer stay;
> - This patient acquired a complication, in that he was unable to urinate requiring reinsertion of a foley catheter for the majority of his stay and;
> - Medicare length of stay for this DRG is 2.7 days and the median length of stay for workers' compensation inpatient admission is three days, whereas the length of stay for this admission exceeds both the Medicare LOS and the median LOS for workers' compensation.

The requestor's categorization of surgeries presupposes that all ankle surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all ankle surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that this type of surgery was unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the requestor does not demonstrate how the services in dispute were unusually extensive in relation to similar surgeries, services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

5. 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 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 and;
   > - It was necessary to purchase expensive implants for use in the surgery.
   >
   > Therefore, additional reimbursement should be ordered under the stop-loss exception.

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. 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. 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 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). The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar 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 in this case does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation make a reasonable comparison between the resources required for this admission and those required for similar surgeries, services or admissions. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to similar surgeries, services or admissions.

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) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *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.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. 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…" The length of stay was five days; however, documentation supports that the Carrier pre-authorized a length of stay of two days in accordance with 28 Texas Administrative Code Rule §134.600. Consequently, the per diem rate allowed is $2,236.00 for the two authorized days.
- 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 $13,280.00.
- The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	QTY.	Cost Per Unit	Cost + 10%
Guided Wire	2	$145.00	$319.00
Tibia Nail	1	$1,075.00	$1,182.50
Device Targeting	1	$195.00	$214.50
Screw Locking	3	$130.00	$429.00
Allomatrix 10cc	1	$1,225.00	$1,347.50
TOTAL	8		$3,492.50

- 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. 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 $5,728.50. The respondent issued payment in the amount of $4,712.50. Based upon the documentation submitted, additional reimbursement of $1,016.00 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 additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,016.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	09/25/2014 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.