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
Tenet Healthcare

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-05-3464-02

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 14, 2005

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 24, 2004 through June 28, 2004	Inpatient Hospital Services	$82,362.45	$0.00
	Total	$82,362.45	$0.00

Requestor's Position

Requestor's Position Statement: "Stoploss-Pays 75% billed charges."

Requestor's Position Statement: "On behalf of Tenet Healthcare, we have reviewed the claim and payment for the above hospital admission. Our findings reveal this claim has not been paid according to the hospital fee guideline published by the Texas Workers Compensation Commission (TWCC). This claim in the amount of $126,032.84 is an inpatient surgical claim in which charges exceed $40,000, the stoploss threshold amount, however, payment is not based on this methodology and we request you to review this for Medical Dispute Resolution as a Fee Dispute … in reviewing the medical record for this patient, his services were extensive. He underwent a 10+ hour extensive back surgery. No there were no complications, but the procedure is extensive in nature … Implant invoices were not provided because they are not required for TWCC Stoploss payment."

Requestor's Supplemental Position Summary Dated January 27, 2005: "On behalf of Tenet Healthcare/Trinity Medical Center, attached you will find the additional documentation relevant to our fee dispute, as requested."

Amount in Dispute: $82,362.45

Respondent's Position

Respondent's Position Summary Dated January 27, 2005: "This dispute involves this carrier's payment for dates of service in dispute for which the requester charged $126,032.84 for a four day inpatient stay for services that were NOT unusually extensive or costly. This carrier reimbursed the requester four days per diem ($1,118 times four) based on the TWCC Acute Care In-Patient Fee Guideline. This carrier also reimbursed the requester fair and reasonable reimbursement plus 10% for Implantables and revenue code 390."

Respondent's Supplemental Position Summary Dated August 21, 2017: "At the request of DWC-MFDR, Texas Mutual is supplementing the record in this dispute to include the petition it filed in Travis County District Court seeking refunds for the erroneously ordered stop-loss reimbursement, which includes the SOAH decision and order and Texas Mutual's Explanation of Benefit showing the amount Texas Mutual was erroneously ordered to pay."

Response Submitted by: Texas Mutual Insurance Co

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. 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 reduced the payment for the disputed services with the following claim adjustment codes:

- F-Fee guideline MAR reduction
- TR-Reimbursed in accordance with the Texas Hospital Fee Guideline. Services do not appear unusually costly.
- Notes: "BILLED CHARGES DO NOT MEET THE STOP-LOSS METHOD STANDARD OF THE 08/01/97 ACUTE CARE INPATIENT HOSPITAL FEE GUIDELINE. THE CHARGES DO NOT INDICATE AN UNUSUALLY COSTLY OR UNUSUALLY EXTENSIVE HOSPITAL STAY. ALLOWING 4 DAYS SURGICAL PER DIEM AT $1118/DAY AS REASONABLE AND NECESSARY."
- M-No Mar
- TM-Services were reimbursed in accordance with the carrier's fair and reasonable, cost data is unavailable for your facility at this time. Additional reimbursement may be considered upon receipt of this information. The intent of stop-loss payment is to compensate hospitals for inpatient stays that are either costly to the facility by an unusually long length of stay or the provisions of unusually costly types of services. The provision of implantables through the facility does not fit either of these situations. Allowing implants at fair and reasonable plus 10%.
- N-Not appropriately documented
- YN-Documentation has not been submitted to substantiate the service.
- YM-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D).
- O – Denial after reconsideration
- YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed

Dispute History

- This dispute was originally decided on April 21, 2005.
- The original dispute decision was appealed to District Court.
- The 200th Judicial District remanded the dispute to the division pursuant to an agreed order of remand D-1-GN-08-000213 dated June 23, 2014.
- As a result of the remand order, the dispute was re-docketed at the DWC's medical fee dispute resolution section.
- M4-05-3464-02 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, 550 (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." 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. Neither party to the dispute submitted a supplemental position. 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 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 extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 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 …" 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 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 $12.30 for personal convenience charges in accordance with §134.401(c)(6)(A)(v). Therefore, the audited charges equal $126,020.54. 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 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.

   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). 28 TAC §134.401(c)(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, in its original position statement, states that "Stoploss-Pays 75% billed charges." 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)(3)(A)(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…" A review of the submitted documentation finds that the length of stay for this admission was four surgical days. Therefore, the standard per diem amount of $1,118.00 multiplied by the four days results 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 $36,712.60. 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 TAC §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 $539.05 for revenue code 390-Blood Processing. 28 TAC §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 390 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

The DWC concludes that the total allowable for this admission is $4,472.00. The respondent issued payment in the amount of $91,848.97. Based upon the documentation submitted, 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 "asks the MFDR to include in its ruling on the proper stop-loss reimbursement amount, a decision on the 'refund' issue …"

   The DWC's medical fee dispute resolution process involves a case-by-case determination of fee disputes presented. The DWC's adjudication of such a claim at this time would be premature. 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

Signature	Medical Fee Dispute Resolution Officer	October 27, 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.