TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Vista Medical Center Hospital

Respondent Name
Merged Into Ace American Ins. Co.-Cigna

MFDR Tracking Number
M4-05-5230-02

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 16, 2005

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 2, 2004 to April 18, 2004	Inpatient Hospital Services	$41,243.29	$0.00

Requestor's Position

Requestor's Position Summary: "M – Code Incorrectly used to designate stop loss reimbursement per the Fee Guideline. N- All TWCC required documentation has been forwarded to the Carrier. U- Preauthorized treatment is not allowed to be retrospectively reviewed for medical necessity. G – Unbundling for this service is prohibited per the fee guideline. Healthcare provider is unable to determine which payment exception codes apply to which charges."

Requestor's Position Summary Dated October 26, 2004: "…TWCC Rule 134.401 requires payment of 75% of audited charges for billed charges that reach the stop-loss threshold of $ 40,000.00."

Requestor's Supplemental Position Summary Dated April 8, 2005: "TWCC Rule 134.401 provides the rules regarding reimbursement for Acute Care In-patient Hospital Fee services. Specifically, reimbursement consists of 75% of remaining charges for the entire admission, after a Carrier audits a bill … The Carrier is allowed to deduct any personal items and may only deduct non-documented services and items and services, which are not related to the compensable injury … The prior amounts paid by the carrier were $57,107.01. Therefore, the Carrier is required

to reimburse the remainder of the Workers' Compensation Reimbursement Amount of **$41,243.29, plus interest**."

Amount in Dispute: $41,243.29

Respondent's Position

Respondent's Statement Dated May 8, 2019: "Vista contended in its Request for Medical Dispute Resolution that it was entitled to payment pursuant to the stop-loss exception to the Acute Care Inpatient Hospital Fee Guideline found in former 28 TEX. ADMIN. CODE §134.401(c)(6) … On June 7, 2005, Ace Insurance Company of Texas (hereinafter 'Ace') requested a contested case hearing before the State Office of Administrative Hearings (hereinafter 'SOAH') … The July 1, 2008, Decision and Order held that '[w]hen a hospital's total audited bill is greater than $40,000, the Division's Stop-Loss Exception applies, and the hospital is reimbursed at 75% of its total audited bill. On July 29, 2008, Ace timely sought judicial review before the Travis County District Court … The Final Judgment reversed the SOAH Decision and Order … and remanded the case to the Texas Department of Insurance, Division of Workers' Compensation for further proceedings …"

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 28 §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:

- M – reduced to fair and reasonable
- N – not documented
- U – unnecessary medical treatment guidelines
- G – included in global charge
- "DISALLOWED PENDING RECEIPT OF INVOICE"
- "PATIENT CONVENIENCE ITEMS ARE NOT ALLOWED PER STATE GUIDELINES."
- "NURSE DENIED SERVICE(S) / PROCEDURE BILLED ORC"
- "DISALLOWED; SERVICES INCLUDED IN THE LISTED VALUE OF THE SURGICAL PROCEDURE."
- "DISALLOWED: BASED ON A UTILIZATION REVIEW PERFORMED BY OUR PHYSICAN ADVISOR. MEDICAL NECESSITY NOT ESTABLISHED."
- 0 – Denial after reconsideration.
- "RECOMMENDED ALLOWANCE IS BASED ON AN INTRACORP NURSE REVIEW"
- "PREVIOUS RECOMMENDATION(S) WILL STAND AS THEY WERE DEFINED AND NO ADDITIONAL RECOMMENDATION IS DUE BASED ON TWCC MEDICAL FEE GUIDLEINES / RULES."

Dispute History

- This dispute was originally decided on June 1, 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-08-002728 dated May 7, 2019.
- As a result of the remand order, the dispute was re-docketed at the DWC's medical fee dispute resolution section.
- M4-05-5230-02 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. 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." A review of the explanation of benefits issued by the respondent finds that the carrier deducted $58.70 for personal convenience items in accordance with §134.401(c)(6)(A)(v); therefore, the audited charges equal $130,360.03. 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 the DWC with a reasonable comparison between the cost associated with this admission when compared to similar spinal surgery services or admissions, thereby failing to demonstrate to the DWC that the admission in

dispute was unusually costly. The DWC concludes that the requestor failed to support that it met 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 requestor's position statement does not address how this inpatient admission was unusually extensive. The requestor does not provide the DWC with a reasonable comparison between the services associated with this admission when compared to similar spinal surgery services or admissions, thereby failing to demonstrate to the DWC 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)(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 16 surgical days; therefore, the standard per diem amounts of $1,118.00 multiplied by the 16 days result in a total allowable amount of $17,888.00.

   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)." Review of the submitted medical bill indicates that the requestor billed revenue code 278 for implants at $3,700.00. The DWC finds the total allowable for the implants billed under revenue code 278 is:

Description	Units	Cost per Unit	Total Cost	Cost + 10%
Kit Resorbable Bead	2	$925.00	$1,850.00	$2,035.00

   Billed services include revenue code 382 for $1,578.75. 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.

   28 TAC §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 documentation finds that the requestor included charges of $289.00 per unit for two doses of Dilaudid PCA 100 ml and $302.30 per unit for two doses of Nasacort AQ 55 mcg/AC. No documentation was found to support the cost of these drugs to the hospital. Therefore, no reimbursement is recommended.

The DWC finds that the total allowable for this admission is $19,923.00. According to the submitted documentation, the respondent issued payment in the amount of $57,107.01. The DWC finds that additional reimbursement cannot 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 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	November 2, 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.