



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

ACE INSURANCE CO OF TEXAS

MFDR Tracking Number

M5-05-2400-02

Carrier's Austin Representative

Box Number 15

MFDR Date Received

JULY 28, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated November 8, 2002: "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 December 15, 2014: "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 laminectomy at L3-L4, L4-L5, L5-S1 and S1-S2 and lumbar fusion at L4-L5, L5-S1 and S1-S2. This complex spine surgery is unusually extensive for the following reasons...The medical and billing records on file with MDR also show that this admission was unusually costly for at least the following reasons."

Amount in Dispute: \$170,929.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated December 31, 2014: "...the Third Court of Appeals held a hospital has to demonstrate that total audited charges exceed \$40,000 and that the admission involved unusually costly and unusually extensive services to receive reimbursement under the stop-loss method...Ace Insurance Company of Texas (Respondent) requested additional documentation from Requestor to substantiate its bill but Requestor has failed to provide such documentation. The entire bill was disputed as not appropriately documented...Respondent authorized a six day inpatient stay for [Claimant]. Respondent has made payment under a fair and reasonable method with additional payment for implantables. Respondent disputed the stop-loss method being applicable to Requestor's hospital services...As previously stated Respondent authorized a six day inpatient stay for [Claimant]. Requestor allegedly treated [Claimant] for seventeen days. Under former Rule 134.401's per diem method, only six days of the inpatient stay were reimbursable. The purpose of the inpatient stay was surgical so the per diem rate is \$1118.00. 28 TEX. ADMIN. CODE § 134.401(c)(2)(A). Therefore Requestor was entitled to payment of \$6708.00 plus implantables of an unknown amount...Respondent paid a total of \$62,700.15 for the services and supplies rendered from August 14, 2002 through August 30, 2002. Therefore Respondent is entitled to and requests a refund of \$18941.85."

Response Submitted by: John D. Pringle, P.C.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
August 14, 2002 through August 30, 2002	Inpatient Hospital Services	\$170,929.88	\$0.00

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 2, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6246, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §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.
4. Former 28 Texas Administrative Code §133.304(p), 17 *Texas Register* 1105, effective February 20, 1992, sets out the procedure for requesting a refund.
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-Allowance based upon invoice cost of device plus 10%.
 - M-Recommended allowance is based on stop loss reimbursement: 75% of covered charges.
 - U, R-Disallowed: per our physician advisor, procedure is not medically or practically justifiable in this case.
 - U-Disallowed pending receipt of medical records and or itemization for services provided.
 - N-Disallowed: Documentation does not support charges.
 - N-Disallowed pending receipt of invoice.
 - R-Disallowed: services do not appear related to work injury/diagnosis.
 - F-Reduction according to medical fee guideline.
 - M-Reduced to fair and reasonable.
 - U-Unnecessary medical treatment guidelines.
 - N-Not documented.
 - R-Extent of Injury.
7. Dispute M4-05-2400 History
 - Dispute was originally decided on July 18, 2005.
 - The original dispute decision was appealed to the State Office of Administrative Hearings (SAOH).
 - SOAH issued a decision.
 - The SOAH decision was appealed to District Court under case number D-1-GN-08-002161.
 - The 126th Judicial District remanded the dispute to the Division pursuant to an agreed order of remand dated November 13, 2013.
 - As a result of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.
 - M4-05-2400-02 is hereby reviewed.

Issues

1. Does a medical necessity issue exist in this dispute?
2. Did the audited charges exceed \$40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?
6. Is the respondent entitled to a refund?

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 dispute supplemented the original MDR submissions. The Division received supplemental positions as noted above. 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, 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...” 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 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. According to the explanation of benefits, the respondent denied reimbursement for charges of \$52,956.28 based upon reason code “U.” A review of the respondent's position summary finds that the issue of medical necessity was not maintained and payment of \$62,700.15 was made to the requestor; therefore, a medical necessity issue does not exist in this dispute.
2. 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, 28 Texas Administrative Code §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 \$80,016.28 charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$148,028.22. The Division concludes that the total audited charges exceed \$40,000.00.
3. 28 Texas Administrative Code §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” and further states that “independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” In its position, the requestor states:

The medical records on file with MDR show this admission to be a complex lumbar laminectomy at L3-L4, L4-L5, L5-S1 and S1-S2 and lumbar fusion at L4-L5, L5-S1 and S1-S2. This complex spine surgery is unusually extensive for the following reasons:

- This type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine;
- 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 type of surgery has the risks of bleeding, nerve root damage, blood clots in the region causing pulmonary embolism, a spinal headache requiring additional treatment in the hospital and the possibility that a drain will be needed to prevent blood from building up at the site,
- Medicare length of stay for this DRG is 5.8 days and the median length of stay for workers' compensation inpatient admissions is three days, whereas the length of stay for this admission of 16 days exceeds both the Medicare LOS and the median LOS for workers' compensation and,
- This patient was in ICU for two days following surgery for compromised breathing. This patient also developed serous drainage requiring medication and a wound-evac delaying recovery.

The requestor's categorization of spinal surgeries presupposes that all spinal 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 spinal 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 all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the Division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. 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 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 because of the potential of blood loss and an arterial line and specialized trained, extra nursing staff were required thereby adding substantially to the cost of the surgery in comparison to other types of surgeries 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 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). 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 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 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 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.

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

- The respondent raises the issue in the position summary that only a six inpatient hospital stay was preauthorized. A review of the submitted documentation did not include a copy of the preauthorization report to support this defense. Division rule at 28 Texas Administrative Code §133.307(j)(2) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or

defenses raised shall not be considered in the review.” A review of the submitted explanation of benefits does not support that the preauthorization issue was raised prior to dispute resolution; therefore, this new denial reason will not be considered further in the review.

- 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...” Review of the submitted documentation finds that the length of stay for this admission was 14 surgical days and 2 ICU/CCU; therefore the standard per diem amounts of \$1,118.00 and \$1,560.00 apply respectively. The per diem rates multiplied by the allowable days result in a total allowable amount of \$18,772.00.
 - 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).” Review of the requestor’s medical bills finds that 31 items were billed under revenue code 0278 at \$106,960.00. The respondent paid \$18,504.00. Review of the medical documentation provided finds that although the requestor submitted an Order Form for items billed under revenue code 278, no invoices were found to support the cost of the implantables. For that reason, no additional reimbursement can be recommended.
 - 28 Texas Administrative Code §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 \$299.00 for revenue code 391-Blood Administration. 28 Texas Administrative Code §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 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
 - 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 PCA100ml; and \$265.35/unit for Thrombin 10,000 unit; \$266.20/unit for Flonase/Flutic 0.05s. 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.
6. In its response to the request for medical fee dispute resolution, the insurance carrier and respondent in this dispute requested “*Respondent is entitled to and requests a refund of \$18941.85.*” Former 28 Texas Administrative Code §133.304(p), 17 Texas Register 1105, effective February 20, 1992, provided, in pertinent part, that “An insurance carrier may request medical dispute resolution in accordance with §133.305 if... the insurance carrier has requested a refund under this section, and the health care provider: (1) failed to make payment by the 60th day after the date the insurance carrier sent the request for refund...” Former 28 Texas Administrative Code §133.305(a)(2)(C), 27 Texas Register 12282, effective January 1, 2003, provided that “a carrier dispute of a health care provider reduction or denial of the carrier request for refund of payment for health care previously paid by the carrier (refund request dispute)” can be a medical fee dispute. Former 28 Texas Administrative Code §133.307(b)(3), 27 Texas Register 12282, effective January 1, 2003, specified that “The carrier... in a dispute involving a carrier’s refund request” may be a requestor in a medical fee dispute. Section 133.307(e) required that “...carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission.” Section 133.307(e)(2)(B) required that the request shall include “a copy of each... response to the refund request relevant to the fee dispute...” The division finds that the insurance carrier’s position statement in response to the health care provider’s request for medical fee dispute resolution does not constitute a request for refund request dispute resolution in the form and manner required by former applicable version of 28 Texas Administrative Code §133.307. Furthermore, no documentation was found to support that the insurance carrier ever presented a refund request to the health care provider to support its burden of proof for a specific refund amount in accordance with §133.304(p). The division concludes that the insurance carrier has not met the requirements of §133.304(p) or §133.307(e). For these reasons, the respondent’s request for an order of reimbursement is not proper, and is not supported. An order of reimbursement for the respondent is therefore not recommended

The Division concludes that the total allowable for this admission is \$18,772.00. The respondent issued payment in the amount of \$62,700.15. Based upon the documentation submitted, no additional reimbursement 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 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 Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

		01/26/2015
Signature	Medical Fee Dispute Resolution Officer	Date

		01/26/2015
Signature	Health Care Business Management Director	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. favor de llamar a 512-804-4812.