Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HCA CONROE REGIONAL MEDICAL CENTER
C/O HOLLAWAY & GUMBERT
3701 KIRBY DRIVE STE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box
#19

Respondent Name

AMERICAN HOME ASSURANCE CO

MFDR Date Received

MARCH 2, 2006

MFDR Tracking Number

M4-06-4328-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated March 1, 2006: "As required by law, Conroe Regional Medical Center billed its usual and customary charges for its services. The total sum billed was $131,353.50… per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%...it is the position of Conroe Regional Medical Center that all charges relating to the admission of [Claimant] are due and payable as provided for under Texas law and the rules of the division, as currently adopted and published at 28 TAC §134.400, *et seq*."

Amount in Dispute: $11,334.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 5, 2013: "Additional 2,067.38 paid. Please see attach EOR for an explanation."

Response Submitted by: Arkansas Claims Management, Inc.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
March 2, 2005 through April 1, 2005	Inpatient Hospital Services	$11,334.74	$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 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 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.

- Effective July 13, 2008, the Division's rule at former 28 Texas Administrative Code § 134.401 was repealed. The repeal adoption preamble specified, in pertinent part: "Section 134.401 will continue to apply to reimbursements related to admissions prior to March 1, 2008." 33 Texas Register 5319, 5220 (July 4, 2008).
- Former 28 Texas Administrative Code § 134.401(a)(1) specified, in pertinent part: "This guidelines shall become effective August 1, 1997. The Acute Care Inpatient Hospital Fee Guideline (ACIHFG) is applicable for all reasonable and medically necessary medical and/or surgical inpatient services rendered after the Effective Date of this rule in an acute care hospital to injured workers under the Texas Workers' Compensation Act." 22 Texas Register 6264, 6306 (July 4, 1997).

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.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- *859 – Re eval letter of explanation will be mailed under separate mailout
- *921 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM – UR/JE
- *481 – REIMBURSEMENT WAS CALCULATED USING THE STOP LOSS METHOD.
- *217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- *225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- *350 – BASED ON THE SUBMITTED DOCUMENTATION FROM THE PROVIDER, WE RECOMMEND AN ADDITIONAL ALLOWANCE BE MADE.
- *710 – THIS CHARGE IS BEING DISALLOWED AS ADDITIONAL/SUPPORTING DOCUMENTATION IS REQUIRED TO CLARIFY SERVICE/SUPPLY RENDERED. PLEASE RESUBMIT.
- 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE CODES WHENEVER APPROPRIATE
- 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
- 42 – CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.
- 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
- 275 – THE CHARGE WAS DISALLOWED; AS THE SUBMITTED REPORT DOES NOT SUBSTANTIATE THE SERVICE BEING BILLED.
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION.
- 268 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE STATE MANDATED FEE SCHEDULE ALLOWANCE. CHARGES HAVE BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
- 876 – REIMBUREMENT EQUALS THE AMOUNT BILLED.
- B12 – SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS.
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM – UR/JE
- 9999 – RECONSIDERATION
- PPO REDUCTION: ROCKPORT NETWORK
- W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE
- Preferred Provider Organization: USAMCO-WIN/ROCKPORT
- MCA RECON REQUESTS PMNT 75% TOTAL CHARGES PREV PMNT 75% DOCUMENTED & APPLICABLE CHARGES RECORD REVIEW FINDS DOC OF MBC 3/21 PREV DENIED.
- MCA RECONSIDERATION, MDR RESPONE: PROVIDER REQUESTS PMNT PER STOP-LOSS METHODOLOGY, AS CHARGES EXCEED $40K, FOR TOTAL $98,515.13. SUBMITS 333 PAGES OF PREVIOUS STOP LOSS RULINGS, AND MEDICAL RECORDS FOR THIS ADMISSION. DETAILED EXPLANATION OF REVIEW BELOW:
- NOTE: PROVIDER'S STATED DISPUTED AMOUNT $11,334.74 INACCURATELY COMPARES EXPECTED FEE SCHEDULE VALUE TO CARRIER'S NET PMNT WITH PPO APPLICATION. CORRECT COMPARISON: $98,768.85 FEE SCHEDULE ALLOWANCE BY CARRIER: $6,746.26.
- Billing for inpatient stay, 30 days, with substantiation for reimbursement per stop-loss methodology, due to documentation of unusually extensive care, lengthy stay, & costly expenses for care. (Multiple surgical procedures, HBO therapy, medical complications requiring ICU stay. This was not disputed with previous reviews & explained in detail in previous correspondence X 3 to provider.
- All documented & applicable charges previously reimbursed 75% billed amount: $122,358.48 documented

charges X 75% = $91,768.86 x 95% RockPort PPO = $87,180.39. Provider confirms this amount paid previously.

- Remainder of charges not found as documented & denied for pmnt in accordance; provider was notified X 3 of need for this documentation. Review of current records finds addtl reports to warrant additional payment, now allowed 75%, PPO 5% reduction applied:
- -Rev code 320, CPT 75827 venography DOS 3/16. Charge $1654.62
- -Rev code 320, CPT 75820 venography DOS 3/16. Charge $1246.96
- Denial of pmnt for the following charges is upheld:
- -Rev code 300, CPT 36415 venipuncture X 13. Charge $1444.25. This procedure is considered inclusive in corresponding lab procedures performed by same provider.
- -Rev code 320, CPT 76001 fluoroscopy 3/3/05. Charge $1027.87. No found as documented.
- -Rev code 320, CPT 76003 fluoroscopy needle guidance, 3/16/05. Charge $830.58. Performed in conjunction with 75820 & 75827 Per AMA/CPT descriptor & CCI Edits, 76003 is inclusive in both of these codes.
- -Rev code 402 ultrasound needle guidance, 3/16/05. Charge $535.19. Performed in conjunction with 75820 & 75827. Per AMA/CPT descriptor & CCH Edits, 76003 in inclusive in both of these codes.
- -Rev code 510 multiple office visits, outpt E/M codes 99211 – 99214. Charge $1738.55. Service associated with these codes are not clearly documented. Inappropriate to bill outpt service codes during Inpatient stay.
- -Rev code 921, CPT 93923 Doppler arterial extremity study. Charge $517. Not documented.
- SUMMARY: $122,358.48 charges prev allowed 75% = $91,768.85…$2,901.58 charges now allowed 75% = $2,176.19…TOTAL FEE SHCED ALLOWANCE $93,945.04, DIFFERENCE OF $4570.08 LESS THAN PROVIDER REQUEST…$6093.44 charges denied for pmnt as not documented, or unbundled X 75% concurs with $4670.08 difference.
- WITH PPO APPLICATION ADDTL PMNT OF $2067.38 IS DUE TO PROVIDER.

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly 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 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. 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 issued by the carrier finds that

the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $131,353.50. The division concludes that the total audited charges exceed $40,000.

2. The requestor in its position statement presumes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. 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 extensive services." The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 Texas Administrative Code §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds $40,000, the stop loss method of payment should apply. 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 thereby affirming 28 Texas Administrative Code §134.401(c)(6) which 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 failed to demonstrate that the particulars of the admission in dispute constitutes unusually costly services; therefore, the division finds that the requestor failed to meet 28 Texas Administrative Code §134.401(c)(6).

4. 28 Texas Administrative Code §134.401(b)(2)(A) titled General Information states, in pertinent part, that "The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:
   (i) a rate for workers' compensation cases pre-negotiated between the carrier and the hospital;
   (ii) the hospital's usual and customary charges; and
   (iii) reimbursement as set out in section (c) of this section for that admission

   In regards to a pre-negotiated rate, the services in dispute were reduced in part with the explanation "Preferred Provider Organization: USAMCO-WIN/ROCKPORT." No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier American Home Assurance and HCA Conroe Regional Medical Center prior to the services being rendered; therefore 28 Texas Administrative Code §134.401(b)(2)(A)(i) does not apply.

   In regards to the hospital's usual and customary charges in this case, review of the medical bill finds that the health care provider's usual and customary charges equal $131,353.50.

   In regards to reimbursement set out in (c), the division determined that the requestor failed to support that the services in dispute are eligible for the stop-loss method of reimbursement; therefore 28 Texas Administrative Code §134.401(c)(1), titled Standard Per Diem Amount, and §134.401(c)(4), titled Additional Reimbursements, apply. 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.

   - 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 twenty nine surgical days and one 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 $33,982.00.

   - 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: (i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619)." A review of the submitted hospital bill finds that the requestor billed $4,750.00 for revenue code 610-MRI. 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 610 would be a fair and reasonable rate of reimbursement. Additional payment cannot 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: (iii) Hyperbaric oxygen (revenue code 413)." A review of the submitted hospital bill finds that the requestor billed $11,991.09.00 for revenue code 413-Hyperbaric O2. 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 413 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 $272.50/unit for Levaquin/D5W 500MG/100 and $299.75/unit for Vancocin/D5W 1GM/200ML. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

  The total reimbursement set out in the applicable portions of (c) results in a total of $33,982.00.

Reimbursement for the services in dispute is therefore determined by the lesser of:

§134.401(b)(2)(A)	Finding
(i)	Not Applicable
(ii)	$131,353.50
(iii)	$33,982.00

The division concludes that application of the standard per diem amount and the additional reimbursements under §134.401(c)(4) represents the lesser of the three considerations. The respondent issued payment in the amount of $89,247.77. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the division concludes that the services in dispute are not eligible for the stop-loss method of reimbursement, that a pre-negotiated rate does not apply, and that application of 28 Texas Administrative Code §134.401(c)(1), titled *Standard Per Diem Amount,* and §134.401(c)(4), titled *Additional Reimbursements*, results in the total allowable reimbursement. Based upon the documentation submitted, the requestor's Table of Disputed Services, and reimbursement made by the respondent, the amount ordered is $0.

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

		04/10/2013
Signature	Medical Fee Dispute Resolution Officer	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.