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

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

Carrier's Austin Representative Box
#05

MFDR Date Received
MARCH 7, 2007

Respondent Name
TRAVELERS PROPERTY CASUALTY CO

MFDR Tracking Number
M4-07-4122-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 27, 2007: "The Carrier denied payment with ANSI payment codes "W1", "W10" and "97" in regard to its reduction in payment…The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges…if the total audited charges for the entire admission are above $40,000, the Carrier shall reimburse using the Stop-Loss Methodology."

Requestor's Supplemental Position Summary Dated February 15, 2013: "Please allow this letter to serve as a supplemental statement to Vista Vista Hospital of Dallas' (VHD) originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeal's Final Judgment… According to the Third Court of Appeals' opinion, a provider is entitled to reimbursement under the 'Stop-Loss' exception in the Acute Care Inpatient Hospital Fee Guideline if the audited charges exceed $40,000 and if the surgery(ies) performed ont he claimant were unusually extensive and unusually costly…When these elements are proven, then the provider is entitled to be paid 75% of its billed charges. The medical records on file with MDR and the additional records attached hereto, show this admission to be a complex five hour spine surgery, specifically a two-level 360 lumbar fusion at L4-S1 and a two-level lumbar laminectomy at L4 to S1 with spinal instrumentation, including lordosis cages, segmental pedicle screw fixation system, bone marrow aspiration, neuro-monitoring and autograft. This complex spine surgery is unusually extensive for at least three reasons; first, this surgery as noted above required extensive spinal instrumentation; second, due to the complexity and extensiveness of the surgery, three surgeons were required and additional trained nursing staff and personnel, specifically two circulating nurses and two scrub techs; and third, the patient post-operatively developed several complications including: urinary retention which required a bladder scan and additional Foley catheters beyond the norm; patient eventually developed an increase in abdominal distension which required a nasogastric tube be placed to relieve the stomach of its contents and there was concern that there was an ileus (bowel obstruction); the patient further developed shortness of breath and atelectasis that required supplemental oxygen for up to three days post-op to keep the saturations above 90%; a CT angiogram had to be performed to rule out pulmonary embolism due to the continued decrease in O2 saturation; the patient further developed post-operative anemia requiring 2 units of Autologuous blood. The medical and billing records on file with MDR also show that this admission was unusually costly for three reasons: first, the Medicare outlier threshold amount for this DRG was $131,658.09. Our charges were $220,842.99 for this case. Therefore, this would qualify for additional reimbursement above the DRG reimbursement; second, it was necessary to purchase expensive implants and sterile medical supplies for use in the surgery. Additionally, specialized equipment was needed…and third, additional trained nurses and personnel were needed…Therefore, reimbursement should be in an amount which is 75% of billed charges which is $165,532.24."

Amount in Dispute: $129,875.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated March 14, 2007: "Bill Note dated 12/11/06 explains that per the Discharge Summary the injured worker had anterior and posterior surgery and a 5 day hospital stay is within limits…Part of the implants are listed in supplies for $24,872.00. Paid cost + 10% = $27,359.20. Another review completed on 1/11/07 determined the bill was paid correctly by per diem. Implants were carved out and paid per cost plus 10%. REV CODE 380 (blood) was carved out and paid in full. All other codes are incidental to the per diem rate. Carrier sustains denial and any additional payment based on bill has been paid correctly, medical does not indicate any extenuating circumstances, and therefore does not meet Stop Loss."

Respondent's Supplemental Position Summary Dated February 11, 2013: "The Provider's bill involves the charges for the hospitalization of the claimant. The Provider billed the Carrier $218,202.99 for the total cost of the 6-day hospitalization for a spinal laminectomy and fusion. The Carrier reimbursed the Provider a total of $33,777.20 based on the surgical per diem rate plus implantables at cost plus ten percent. There were no complications, and the admission was neither unusually extensive nor costly for the condition and treatment… The Provider has not shown that the stop-loss provision applies for this hospitalization…The Carrier contends the Provider is not entitled to additional reimbursement."

Responses Submitted by: Travelers, 1501 S. Mopac, Suite A320, Austin, TX 78746

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 28, 2006 through October 3, 2006	Inpatient Hospital Services	$129,875.04	$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 §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
4. 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.
5. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, 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

- SDAY – W1 – Workers compensation state f/s adj. If reduction, then procesed according to the Texas fee guidelines.
- INCL – 97 – Payment is included in the allowance for another service/procedure. If reduction, then processed according to the Texas fee guidelines.
- 97-Payment is included in the allowance for another service/procedure. This procedure is considered integral to the primary procedure billed.

- DOP – W10 – No maximum allowable defined by fee guideline. Reduced to fair & reasonable. No MAR has been set by TWCC in the medical fee guideline.

- W4 – No add'l reimbursement is allowed after reconsideration. Aud charges do not exceed $40k the stop loss provisions do not apply.
- W4-No additional reimbursement allowed after review of appeal/reconsideration. After carefully re-viewing the resubmitted invoice, additional reimbursement is not justified.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
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?

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 §133.240(a) and (e), 31 Texas Register 3544, effective May 2, 2006 and applicable to the dates of service, state, in pertinent part, that " (a) An insurance carrier shall take final action after conducting bill review on a complete medical bill…" and "(e) The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division… " Furthermore, 28 Texas Administrative Code §133.2, 31 Texas Register 3544, states, in pertinent part "(4) Final action on a medical bill-- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill."

   The requestor in its position statement asserts that: "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges."

   Review of the submitted documentation finds that the explanation of benefits was issued using the division prescribed form TWCC 62 and noted payment exception codes of "SDAY-W1, 97, DOP-W10, INCL-97 and W4".

   These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. 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) for the services in dispute. The division therefore concludes that the insurance carrier has met the requirements of applicable §133.240, and §133.2.

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, (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 $218,202.99. The Division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement asserts that "…if the total audited charges for *the* entire admission are above $40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). The rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the $40,000 stop-loss threshold is reached." 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. 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 and the additional records attached hereto, show this admission to be a complex five hour spine surgery, specifically a two-level 360 lumbar fusion at L4-S1 and a two-level lumbar laminectomy at L4 to S1 with spinal instrumentation, including lordosis cages, segmental pedicle screw fixation system, bone marrow aspiration, neuro-monitoring and autograft. This complex spine surgery is unusually extensive for at least three reasons; first, this surgery as noted above required extensive spinal instrumentation; second, due to the complexity and extensiveness of the surgery, three surgeons were required and additional trained nursing staff and personnel, specifically two circulating nurses and two scrub techs; and third, the patient post-operatively developed several complications including: urinary retention which required a bladder scan and additional Foley catheters beyond the norm; patient eventually developed an increase in abdominal distension which required a nasogastric tube be placed to relieve the stomach of its contents and there was concern that there was an ileus (bowel obstruction); the patient further developed shortness of breath and atelectasis that required supplemental oxygen for up to three days post-op to keep the saturations above 90%; a CT angiogram had to be performed to rule out pulmonary embolism due to the continued decrease in O2 saturation; the patient further developed post-operative anemia requiring 2 units of Autologuous blood."

   The requestor did not submit documentation to support the reasons asserted that this spinal surgery was unusually extensive in relation to similar spinal surgery services or admissions. The reasons stated are therefore not demonstrated. 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 three reasons: first, the Medicare outlier threshold amount for this DRG was $131,658.09. Our charges were $220,842.99 for this case. Therefore, this would qualify for additional reimbursement above the DRG reimbursement; second, it was necessary to purchase expensive implants and sterile medical supplies for use in the surgery. Additionally, specialized equipment was needed…and third, additional trained nurses and personnel were needed."

   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 both types of surgeries. Therefore, the reqeustor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

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) 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. The surgical per diem rate of $1,118.00 multiplied by the length of stay of five days results in an allowable amount of $5,590.00.
- 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)."
- A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $89,295.00.
- The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
ACCELL Connexus	1	$1,350.00	$1,485.00
Anterior Implant	2	$4,800.00/each	$10,560.00
Screw Incompass	7	$1,240.00/each	$9,548.00
Closure Tops	6	$150.00/each	$990.00
Rod Prebent	2	$475.00/each	$1,045.00
TOTAL	18		$23,628.00

- 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: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $828.00 for revenue code 380-Blood-General. 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 380 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 $330.05/unit for Thrombin USP TOP. 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 division concludes that the total allowable for this admission is $29,218.00. The respondent issued payment in the amount of $33,777.20. 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 no additional reimbursement can be recommended.

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 reimbursement for the disputed services.

Authorized Signature

		03/05/2014
Signature	Medical Fee Dispute Resolution Officer	Date
		03/05/2014
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.