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 and Address
TWELVE OAKS MEDICAL CENTER
C/O FRANCIS, ORR & TOTUSEK, LLP
103 EAST VIRGINIA STE 203
MCKINNEY TX 75069

Carrier's Austin Representative Box
05

MFDR Date Received
August 14, 2007

Respondent Name
ST PAUL FIRE & MARINE INSURANCE

MFDR Tracking Number
M4-07-8129

REQUESTOR'S POSITION SUMMARIES & NOTICES

Requestor's Position Summary Dated August 13, 2007: "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%."

Position submitted by: Francis, Orr & Totusek, L.L.P., 103 East Virginia Suite 203, McKinney, Texas 75069

Requestor's Position Summary Dated November 29, 2011: "This firm and the undersigned have been retained by GE Business Financial Services, Inc. ("GEBFS"), a secured creditor of Twelve Oaks Medical Center ("TOMC"), the Requestor, located in Houston, Texas, which holds a security interest in certain TOMC accounts, including the account referenced above. GEBFS is authorized to pursue collection of the account, as attorney in fact for TOMC, in an effort to obtain payment for the medical services and goods provided to the Claimant in reference to the above-captioned workers' compensation medical dispute resolution matter.

Position submitted by: Francis, Orr & Totusek, L.L.P., 103 east Virginia, Suite 203, McKinney, Texas 75069
Cc: Mr. Steven M. Tipton, Flahive, Ogden & Latson, P.O. Drawer 201329, Austin, TX 78720

The Law firm of Francis, Orr & Totusek, L.L.P has represented that it is the attorney-in-fact for Twelve Oaks Medical Center.

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Respondent did not submit a position statement

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
August 14, 2006 through August 18, 2006	Inpatient Hospital Services	$78,195.32	$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 for the date of admission in dispute.
    - 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. Dispute M4-07-8129 was originally decided on September 24, 2008 and subsequently appealed to a contested case hearing at the State Office of Administrative Hearings (SOAH) under case number 454-09-0750.M4. This dispute was then remanded to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) pursuant to a November 21, 2008 SOAH order of remand. As a result of the remand order, the dispute was re-docketed at medical fee dispute resolution and is hereby reviewed.
4. Case No. 08-11264 (BLS), related to Docket No. 397 in the United States Bankruptcy Court for the District of Delaware, regarding River Oaks Holdings, Inc., et al (Debtors), including River Oaks Medical Center, L.P. (d/b/a Twelve Oaks Medical Center under NPI 1598758765, and Medicare number 450378 according to the medical bills) was dismissed on December 2, 2009. The Division therefore proceeds with the adjudication of this medical fee dispute.

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

Explanation of Benefits

- 45 – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
- 45 – THE BILL HAS BEEN REDUCED ACCORDING TO THE PROVIDER'S CONTRACT WITH SUB-NETWORK.
- W1 – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF
- 080 – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF $0.00
- 080 – REVIEW OF THIS BILL AHS RESULTED IN AN ADJUSTED REIMBURSEMENT OF $26,733.30
- 080 – REVIEW OF THIS BILL HAS REUSLTED IN AN ADJUSTED REIMBURSEMENT OF $4,472.00
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT $0.00
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT $26,733.30
- W1 – WPRLERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT $4,472.00

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 supplemented the original MDR submissions. The division received supplemental positions as noted above. Positions were exchanged among the parties as appropriate. The 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…" 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 $145,867.49. The division concludes that the total audited charges exceed $40,000.

2. The requestor in its position states "The services provided by TOMC were unusually extensive…the services rendered to the claimant involved multiple surgical procedures…These procedures were also complicated." The Third Court of Appeals in its November 13, 2008 opinion stated that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that an admission involved…unusually extensive services." Although the requestor gave some particulars associated with the admission in dispute, it failed to compare the services in dispute to similar surgeries or admissions, thereby failing to demonstrate that the particulars of the admission in dispute constitute unusually extensive services. The division finds that the requestor did not meet the requirements of 28 Texas Administrative Code §134.401(c)(6).

3. 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 Third Court of Appeals' November 13, 2008 opinion affirmed that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. Furthermore, the Third Court stated "What is unusually costly and unusually extensive in any particular fee dispute remains a fact-intensive inquiry best left to the Division's determination on a case-by-case basis…The scope of this authority includes the discretion to determine whether those standards have been met."

   The requestor's first contends that "The services provided by TOMC were…unusually costly." In support of its contention that the services in dispute were unusually costly, the requestor states "A measure of the costliness of the services provided by TOMC is by comparison of the claim in question to other workers' compensation hospital, in-patient claims in Texas. According to a recent study conducted by the Workers' Compensation Research Institute, the average hospital in-patient payment per claim in Texas during the period of 2006 was between $15,000 - $16,000. Thus, in comparison to other Texas hospital, in-patient claims, the services provided were unusually costly." The requestor puts forth an average payment of $15,000 - $16,000 as a standard of comparison, but then it fails to compare that average to any factor specific to the "claim in question" (the services in dispute). Additionally, an average payment in Texas during 2006 for all in-patient hospitalizations does not provide information on an average or median payment for similar surgeries to the in-patient services involved in this case and, therefore does not establish that the services in this case were unusually costly when compared with similar services provided in other cases during 2006 in Texas. The "stop-loss" exception to "per-diem" reimbursement rates in the rule "…was meant to apply on a case-by-case basis in relatively few cases…" as noted in the 2008 appellate court opinion specified in the initial paragraph of the "Findings" above.

The requestor offers a second position in support of its assertion that the services in dispute were unusually costly. In pertinent part, the requestor states "Another measure of the costliness of services is to review the costs incurred by the hospital in providing such services. Deriving the actual costs of an admission is difficult…However; estimates of certain costs are available through the Centers for Medicare and Medicaid Services ('CMS'). The costs, which are reported to CMS by the specific facility, may be used to achieve an *estimated and general* cost-to-charge ratio, for a specific facility for all in-patient services. For TOMC, the reported cost-to-charge ratio for the time period in which the above referenced services were provided was 0.278 to 1. Applying this ratio to the amount of charges (excluding implants) on the claim in issue results in an *estimate* of TOMC's direct costs in providing services of $15,847.53. This cost amount alone (excluding emplants) equates to the average Texas hospital in-patient claim payment. More importantly, This cost is significantly more than the amount paid by the carrier under the per diem method of payment, which was $4,472 (excluding implants)." Although the requestor cites a CMS inpatient provider specific file dated October 2011 as it source for the cost-to-charge ratio (CCR) of 0.278, a search of CMS impact files for Inpatient Prospective Payment System (IPPS) finds that TOMC's Medicare number 450378 (as noted on the disputed medical bills) has no assigned operating CCR or capital CCR for 2011. In addition, the requestor failed to discuss *how* a CCR from 2011 would apply to cost to the hospital for services provided in 2004. The requestor in its own position has failed to determine, calculate or reasonably estimate the cost to the hospital for the services in this dispute. Furthermore, the requestor attempts to compare the unsupported CCR to the Per Diem allowable without discussing or demonstrating how the disputed services are unusual when compared to similar surgeries or admissions.

In both its assertions, the requestor has failed to discuss or demonstrate how the services in dispute are unusually costly when compared to similar surgeries or admissions.

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 "45 – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE and 45 – THE BILL HAS BEEN REDUCED ACCORDING TO THE PROVIDER'S CONTRACT WITH SUB-NETWORK." No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier (St Paul Fire & Marine Insurance), and the hospital (Twelve Oaks 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 $145,867.49.

   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 four surgical days; therefore the standard per diem amounts of $1,118.00 applies. The per diem rates multiplied by the allowable days result in a total allowable amount of $4,472.00.
   - 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 $384.00 for revenue code 382 – Blood and $96.00 for revenue code 390 – Blood prcessing. 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 codes 382 and 390 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

- 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 35 items were billed under revenue code 0278. These items are eligible for separate payment under §134.401(c)(4)(A) as follows:

	Charge Item Number	Itemized Statement Description	Cost Invoice Description	Cost (one unit of each was billed)	Cost + 10%
1	278	7.0 x 50 MM Screw	7.0 mm x 50 mm Pungea Screw	34 units billed only 1 unit is supported at $1,103.00	$1,213.30
2	278	KIT FOLEY INFEC	NO INVOICE PROVIDED	$0.00	$0.00
				TOTAL ALLOWABLE:	$1,213.30

The total reimbursement set out in the applicable portions of (c) results a total allowable of $5,685.30.

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

§134.401(b)(2)(A)	Finding
(i)	Not Applicable
(ii)	$145,867.49
(iii)	$5,685.30

The division concludes that the total allowable for this admission is $5,685.30. The respondent issued payment in the amount of $31,205.30. 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, failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(b)(2)(A) applies and results 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

Signature	Medical Fee Dispute Resolution Officer	1/9/14 Date

		1/9/14
Signature	Medical Fee Dispute Resolution Manager	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

CC:
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