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

General Information

Requestor Name
Vista Medical Center

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-03-3707-02

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 27, 2003

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 2, 2002	Preoperative Services	$318.81	$0.00
April 5, 2002 – April 9, 2002	Inpatient Hospital Services	$30,940.88	$0.00
	Total	$31,259.69	$0.00

Requestor's Position

"The only payment exception codes utilized by the Carrier in this instance was 'F' indicating payment was made per the Acute Care In-patient Hospital Fee Guideline. However, the Carrier did not reimburse pursuant to the TWCC Fee Guideline …

"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. See Tex. Admin. Code Section 133.401(c). This figure is presumptively considered to be 'fair and reasonable' in accordance with the preamble of TWCC Rule 134 …

"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. At that time, if the total audited charges for the entire admission are below $40 ,000, the Carrier may reimburse at a 'per diem' rate for the hospital services. However, if the total audited charges for the entire

admission are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission' …

"In this instance, the audited charges that remained in dispute after the last bill review by the insurance carrier were $41,254.50. There was no indication by the Carrier that any charges had been 'deducted' from the billed charges as a result of any personal items, lack of documentation, or items unrelated to the compensable injury. There was no indication by the Carrier on the EOB that any charges had been reduced due to 'usual and customary' reductions.

"In accordance with TWCC Rule 134.401 and QRL 01-01, the total amount of reimbursement due to the hospital is $30,940.88. This amount is derived from the formula presented in 133.401 (c)(6)(B), (C). Specifically, the audited charges ($41,254.50) - deducted charges (none per the EOB) x .75 = ($30,940.88.). The prior amounts paid by the carrier were $91.00 …

"In addition, Vista Medical Center provided billed charges in the amount of $1,435.83 for pre-op services. The prior amounts paid by the carrier were $260.88. Therefore, Vista Medical Center is also entitled to $318.81 in addition to the $30,849.88, for a total of $31,168.69, plus interest."

Amount in Dispute: $31,259.69

Respondent's Position

"The following is the carrier's statement with respect to this dispute. This dispute involves the carrier's denial of payment for dates of service 04/02/02 and 04/05/02-04/09/02.

"**1. Regarding charges for date of service 04/02/02 (which was paid on this carrier's invoice #000002844413 indicating DOS 04/05/02):**

"This carrier reimbursed the requester a fair and reasonable reimbursement as follows:

"Revenue code	CPT/HCPCS	Charge	MAR
300	80053	132.14	40 (80050)
	85025	134.55	14.00
	85610	53.76	5.00
	85730	49.33	9.00
	86900	179.40	9.000 [*sic*]
	86920	322.00	19.00
			871.18

"Revenue code	CPT/HCPCS	Charge	MAR
324	71010	85.10	24.00
730	93005	138.00	26.00

"It appears this carrier inadvertently reimbursed the requester for revenue code 270 which is for supplies. Apparently, the requester was billing for a PICK-UP FEE and no supplies. This would imply this is a hospital without a laboratory.

"It also appears this carrier inadvertently reimbursed the requester for blood, revenue code 382

billed with HCPCS code P9010. First, the medical necessity for the patient to receive a transfusion on 04/02/02 is not apparent and not substantiated in documentation …

"**2. Regarding DOS 03/12/02-03/19/02** [*sic*]**-**

"This dispute involves this carrier's payment for _____date of service 04/05-09/02 for which the requester charged $48,082.28 or $12020.50 a for services that were NOT unusually extensive or costly …

"The issues in this case are this carrier's right to audit the charges and fair and reasonable reimbursement for implants. It is this carrier's position the requester has not supported reimbursement in the amount billed, that 75% is due for the implants, or that the charges in dispute were unusually costly or that the services were unusually extensive.

"… This carrier was provided NO DOCUMENTATION to support that the services were unusually costly or extensive. This carrier reimbursed the requester $5,211.84 … The maximum allowable reimbursement for a 4 day inpatient surgical stay that was NOT unusually costly or extensive would be $$4,472 [sic]. Therefore, this carrier inadvertently reimbursed the requester $739.84 too much.

"… The billing and documentation does not support the injured worker required extensive services or unusually costly services … Based on the records available, the hospital stay was uneventful … Because there is nothing to support that the services were unusually extensive or unusually costly, this carrier reimbursed the requester the per diem of an in-patient surgical stay."

Response Submitted by: Texas Mutual Insurance Company

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 – No Mar
- M – The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(b).
- F – Fee guideline MAR reduction.
- Notes: "THE CHARGE FOR THE PROCEDURE EXCEEDS THE AMOUNT INDICATED IN THE FEE SCHEDULE."

Dispute History

- This dispute was originally decided on September 27, 2004.
- The original dispute decision was appealed to District Court.
- The 261st Judicial District remanded the dispute to the division pursuant to an agreed order of remand D-1-GN-07-003912 dated June 21, 2011.
- As a result of the remand order, the dispute was re-docketed at the DWC's medical fee dispute resolution section.
- M4-03-3707-02 is hereby reviewed.

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 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, 550 (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."

Consistent with the Third Court of Appeals' November 13, 2008, opinion, 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 extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 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…" 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 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." Review of the explanation of benefits issued by the respondent finds that the carrier did not deduct any charges in accordance with 28 TAC §134.401(c)(6)(A)(v). Therefore, the audited charges equal $49,518.11. 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 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.

   The requestor's position statement does not address how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar spinal surgery services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The DWC concludes that the requestor failed to meet 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). 28 TAC §134.401(c)(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 costly and unusually extensive services." It further states that "independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases."

   The requestor states that "In accordance with TWCC Rule 134.401 and QRL 01-01, the total amount of reimbursement due to the hospital is $30,940.88. This amount is derived from the formula presented in 133.401 (c)(6) (*B*), (C). Specifically, the audited charges ($41,254.50) - deducted charges (none per the EOB) x .75 = ($30,940.88)." This statement does not meet the requirements of 28

TAC §134.401(c)(2)(C) because the requestor presumes that the disputed services meet the stop-loss exception since the billed amount was over $40,000.00, thereby presuming that the admission 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)(A)(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 …" A review of the submitted documentation finds that the length of stay for this admission was four surgical days; therefore, the standard per diem amount of $1,118.00 multiplied by the five days result in a total allowable amount of $4,472.00.

   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 the following charges:

   - April 5, 2002: D5W 250 cc IY Solu - $310.48
   - April 5, 2002: Vanocin 1 gm inj - $441.60
   - April 5, 2002: PCA Pump - $345.00

   Insufficient documentation was found to support the cost of these drugs to the hospital. Therefore, no additional reimbursement is recommended.

   Billed services include revenue code 391 for $299.00. 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 additional reimbursement is recommended.

   This dispute also includes charges for preoperative services for date of service April 2, 2002. No documentation was found to support the services in question. Therefore, no reimbursement is recommended.

   The DWC concludes that the total allowable for this admission is $4,472.00. The respondent issued payment in the amount of $5,472.72. Based upon the documentation submitted, additional reimbursement cannot be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requester 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

		January 6, 2025
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 complete 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 a 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 as 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.