

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor NameVista Medical Center
Hospital**Respondent Name**

Texas Mutual Insurance Co.

MFDR Tracking Number

M4-04-6267-02

Carrier's Austin Representative

Box Number 54

DWC Date Received

February 9, 2004

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 21, 2003 to March 24, 2003	Inpatient Hospital Services	\$64,338.77	\$0.00

Requestor's Position

"In this instance, the audited charges that remained in dispute after the last bill review by the insurance carrier were \$101,734.47. The prior amounts paid by the carrier were \$11,962.08. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of **\$64,338.77 plus interest.**"

Amount in Dispute: \$64,338.77

Respondent's Position

"This carrier reimbursed the requester surgical per diem for a hospital stay that was NOT unusually costly (just unusually charged) and NOT unusually extensive. Peer review of this hospital stay did not reveal any unusually costly or extensive services. ...This carrier reimbursed the requester the TWCC per diem for the inpatient stay. The requester was also reimbursed cost as represented by invoices plus 10% and this carrier's fair and reasonable reimbursement for revenue code 391."

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.
- F – Fee guideline MAR reduction.
- O – Denial after reconsideration.
- N – Not appropriately documented.
- A – Preauthorization required but not requested.
- S – Supplemental payment.
- YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed
- TR – Reimbursed in accordance with the Texas Hospital Fee Guideline. Services do not appear unusually costly.
- YM – 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 (D).
- JL – Length of stay exceeds number of days previously precertified/preauthorized. Documentation does not support medical necessity for additional days.

- JF – Documentation submitted does not substantiate the service billed.
- YU – This service has been deemed unnecessary medical treatment based on a review of the claim file, billing records, and/or written review protocols established for appropriate health care treatment.
- YM – 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 (D). Payment is for LSO Back Brace at invoice plus 10%.
- YS – Supplemental payment Billed charges do not meet the stop-loss method standard of the 08/0197 acute care inpatient fee guideline. The charges do not indicate a usually costly or unusually extensive hospital stay. There is no documentation in the claim file that indicates that unusual or extensive services were provided that would substantiate average daily charges of \$22683.66/day excluding implants and back brace.

Dispute History

- This dispute was originally decided on June 28, 2005.
- 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-08-002593.
- As a result of the remand order, the dispute was re-docketed at the DWC's medical fee dispute resolution section.
- M4-04-6267-02 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 \$101,608.97. 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, in its original position statement, states that "...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.'" 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 three surgical days; therefore, the standard per diem amount of \$1,118.00 multiplied by the three days result in a total allowable amount of \$3,354.00.

28 TAC §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 \$28,483.00.

The submitted itemized statement indicates the following items billed under Revenue code 278.

- Poly Screw 1 unit billed price \$3500.00
- Poly Screw 1 unit billed price \$3500.00
- Monarch Screw 5 units billed price \$3780 each total price \$18,900.00
- Monarch Rod 2 units billed price \$1350.00 each total price \$2700.00
- Monarch Cap TI 6 units billed price \$918.00 each total price \$5508.00

The document titled "invoice" included with this dispute has an order date of March 24, 2003. The date of surgery was March 21, 2003. The invoice submitted is for items ordered after the date of surgery and three of the items listed are illegible. No additional payment is recommended.

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 charges of \$1708.55 each for Tobramycin 1.2gm. No 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. The submitted explanation of benefits indicates a payment of \$185.38. Per 134.401(c)(4)(B)(iv), revenue codes 380-399 shall be reimbursed at a fair and reasonable rate. The requestor submitted no evidence to support a fair and reasonable rate for these charges. Therefore, no additional

reimbursement is recommended.

The DWC concludes that the total allowable for this admission is \$3,354.00. The respondent issued payment in the amount of \$11,982.76. 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 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 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

Signature

Medical Fee Dispute Resolution Officer

December 27, 2024

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 MFDR 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 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