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

General Information

Requestor Name
Vista Medical Center Hospital

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-04-6360-02

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 11, 2004

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 30, 2003 to July 3, 2003	Inpatient Hospital Services	$62,817.35	$0.00

Requestor's Position

"...in this instance, the Carrier has severely under-reimbursed the billed charges, despite the clear language in the Texas Administrative Code and further clarification provided by the TWCC in QRL 01-03. In this instance, the audited charges that remained in dispute after the last bill review by the insurance carrier were $91,484.47. The prior amounts paid by the carrier were $5,796.00. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of $**62,817.35, plus interest**."

Amount in Dispute: $62,817.35

Respondent's Position

"As the respondent in this dispute, the carrier further asserts it has properly completed Parts II, III, V and VI of the TWCC-60 form as required by Rule 133.307."

Response Submitted by: Texas Mutual

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:

- O – Denial after reconsideration
- F – Fee guideline MAR reduction
- YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed
- M – No mar
- 01 – The charge for the procedure exceeds the amount indicated in the fee schedule. Charges exceed usual and customary for patient undergoing similar surgeries. There is no documentation on file that extensive or usual services were provided that would substantiate average daily charges of 22070.98 excluding implants.
- 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
- TM – Services were reimbursed in accordance with the carrier's fair and reasonable; cost data is unavailable for your facility at this time. Additional reimbursement may be considered upon receipt of this information.
- JM – The medical fee guideline states in the importance of proper coding "Accurate Coding of services rendered is essential for proper reimbursement", the service performed are not reimbursable as billed.

Dispute History

- This dispute was originally decided on April 25, 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 D-1-GN-08-001697 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.
- M4-04-6360-02 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 $91,484.47. 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 "…the Carrier has severely under-reimbursed the billed charges, despite the clear language in the Texas Administrative Code and further clarification provided by the TWCC in QRL 01-03." 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 resulted 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 278)." A review of the submitted medical bill indicates that the requestor billed revenue code 278 for implants at $25,272.00.

The following items were billed under revenue code 278 on the itemized statement.

- Monarch Screw billed amount $3780 multiplied by five units for a total billed amount of $18,900.00. Submitted invoice indicates unit price of $945.00 multiplied by five units for a total cost of $4,725.00.
- Monarch Rod billed amount $1350 multiplied by two units for a total billed amount of $2,700.00. Submitted invoice indicates unit price of $265.50 multiplied by two units for a total cost of $531.00.
- Monarch CAP TI billed amount $918.00 multiplied by four units for a total billed amount $3,672.00. The submitted invoice indicates unit prices of $229.50 multiplied by four units for a total cost of $918.00.

Review of the submitted operative report only found reference to the 3screws and rods. These items were found to be implanted and eligible for reimbursement.

The total cost of the supported implants was $5,256.00 multiplied by 10% = $5,781.60.

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 for Tobramycin 1.2gm and $289.00 for Dilaudid PCA 100m. for three doses. 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. 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 $9,135.60. The respondent issued payment in the amount of $5,796.00.

Review of information known to the Division indicates a payment of $82,560.21 was made for these services in dispute at a later date. No additional payment is 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

		December 27, 2024
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 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