Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 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 TEXAS 77504

Carrier's Austin Representative Box
Box 01

MFDR Date Received
JANUARY 20, 2006

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-06-3453-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 6, 2006: "The amount the Carrier paid Vista Hospital Of Dallas for the services provided in this case was not fair and reasonable and therefore, not in compliance with the applicable statutes and regulations. Vista Hospital Of Dallas charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Hospital Of Dallas is at a minimum 70% of billed charges. This is supported by the Focus managed care contract. This managed care contract exhibits that Vista Hospital Of Dallas is requesting reimbursement that is designed to ensure quality medical care is provided and to achieve effective medical cost control. It also shows numerous Insurance Carriers' willingness to provide 70% reimbursement for Out-Patient Hospital setting medical services. As a result, the reimbursement requested by Vista Hospital Of Dallas is not in excess of the fee charged for similar treatment of an individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf, as evidenced by the managed care contract."

Requestor's Supplemental Position Summary Dated February 18, 2013: "This claim is for hospital outpatient services and not for hospital inpatient services as the carrier had incorrectly processed the claim. This claim was appropriately submitted as a hospital outpatient claim, as it was classified as 23 hours observation only. The treating physician specifically ordered a 23 hour observation as evidenced by his post-op orders, attached hereto. Also, there was not a room charge on the UB92 but instead 21 hours of observation were charged on the UB92 as attached hereto. The standard per diem rate of $1,118.00 is not appropriate in this case."

Amount in Dispute: $30,328.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 3, 2006: "The claimant was admitted on 5/16/05 at 6:00am and discharged on 5/17/05 at 8:00am. The claimant was in the facility over 23 hours. Per the Texas Acute Care Inpatient Fee Guideline, anything over 23 hours is considered an inpatient. The provider was reimbursed per the Texas Fee Schedule inpatient surgical per diem $1118.00. No carve out revenue codes billed."

Response Submitted by: Liberty Mutual Insurance Co.

Respondent's Supplemental Position Summary Dated February 12, 2013: "The Claimant was admitted to the facility at 6a.m. on May 16, 2005. He was discharged at 8 a.m. the following morning, May 17, 2005. As his stay exceeded 23-hours, the health care at issue in this dispute is deemed inpatient and thus subject to the Acute Care Inpatient Hospital Fee Guidelines See former 28 TEX. ADMIN. CODE §134.401(b)(1)(B). Per the ACIHFG,

the workers' compensation standard per diem rate is $1,118 – which is precisely what Liberty paid. No additional monies are due at this time."

Response Submitted by: Hanna & Plaut, L.L.P.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
May 16, 2005 through May 17, 2005	Inpatient Hospital Services	$30,328.80	$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* 6246, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §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.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M- Reduced to fair and reasonable.
   - Z585-The charge for this procedure exceeds fair and reasonable.
   - F-Fee guideline MAR reduction.
   - Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - Z652-Recommendation of payment has been based on a procedure code which best describes services rendered.
   - X394-Our position remains the same; if you disagree with our decision please contact the TWCC Medical Dispute Resolution.

Issues

1. Do the disputed services meet the definition of "inpatient hospital services" per 28 Texas Administrative Code §134.401(b)(1)(B)?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.401(b)(1)(B), states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

   A review of the submitted documentation support that claimant was admitted to the hospital and whose length of stay exceeded 23 hours; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B). Therefore, reimbursement is recommended in accordance with 28 Texas Administrative Code §134.401.

2. 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 one surgical day, all of which were preauthorized by the workers' compensation insurance carrier; therefore, the standard per

diem amount of $1,118.00 applies. The per diem rate multiplied by the length of stay results in a total allowable amount of $1,118.00.

The division concludes that the total allowable reimbursement for this admission is the SPDA of $1,118.00. The respondent issued payment in the amount of $1,118.00. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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

		01/17/2014
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 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.