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 MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TEXAS 77504

Carrier's Austin Representative Box
Box 55

MFDR Date Received
NOVEMBER 29, 2005

Respondent Name
LOUISIANA PACIFIC CORP

MFDR Tracking Number
M4-06-3910-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 10, 2006: "Please be advised that **Vista Medical Center Hospital is withdrawing the Medical Necessity Dispute** for **DOS 02/04/05** attached is the amended table."

Requestor's Supplemental Position Summary Dated February 13, 2006: "The Carrier's denial of reimbursement on the basis that Vista provided 'unnecessary medical treatment and or service' was erroneous. The Carrier preauthorized the surgery in question…Further, the Carrier has severely under-reimbursed Vista Medical Center Hospital by applying the inappropriate reimbursement methodology…if the total audited charges for the entire admission are above $40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii)."

Requestor's Supplemental Position Summary Dated November 10, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment… The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons…The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons."

Amount in Dispute: $129,801.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated December 10, 2005: "paid fair & reasonable based on documentation."

Response Submitted by: Downs Stanford, P.C.

Respondent's Supplemental Position Summary Dated December 19, 2005: "Based on Hospital Fee Guidelines, Requestor attempted to invoke the Stop-Loss provision of Commission Rule 134.401 and sought reimbursement of $243,418.86. Respondent properly paid $52,763.10 based upon the documentation submitted by Requestor using the denial code 'F' – reduced per Fee Guidelines. The Carrier paid a fair and reasonable amount based on the documentation presented. Some charges were unbundled from the surgical procedures. Other charges appear to be not medically necessary based on the documentation provided. Additionally, as

Requestor has failed to document exactly how or why the services it provided were unusually extensive or costly, it is due no further reimbursement."

Response Submitted by: Downs Stanford, P.C.

Respondent's Supplemental Position Summary Dated February 13, 2006:

Respondent's Supplemental Position Summary Dated September 7, 2011: "This will serve as my letter of representation of Louisiana Pacific Corporation. I am the Austin representative for Louisiana Pacific Corporation, as well as the attorney representing their interest in workers compensation disputes at the DWC."

Response Submitted by: Christopher J. Ameel, P.L.L.C

Respondent's Supplemental Position Summary Dated September 22, 2011: "Attached is the Table of Disputed Services outlining the basis for its methodology, and the Respondent's rationale for maintaining denial of the bills based on medical necessity while paying the bills based on the fair and reasonable method…The Provider/Requestor has failed to provide an itemized copy of all payments received by the Provider/Requestor for any and all services to justify its usual and customary rate not only for its facility, but also a usual and customary rate for the same or similar facility in the same geographic area. As previously stated, the Provider/Requestor's charges must comply with the statutory requirement set forth in Texas Labor Code §413.011(d), which mandates that 'Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.' The Requestor has failed to explain how it supports its charges or its request seeking additional reimbursement. The Requestor has failed to demonstrate that it billed its usual and customary charges for this stay, as instructed by Rule 134.401(b)(2)(A). Respondent paid a fair and reasonable rate in accordance with the Fee Guidelines."

Responses Submitted by: Christopher J. Ameel, P.L.L.C

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
January 27, 2005 through February 4, 2005	Inpatient Hospital Services – Revenue Code 278 for Implants	$129,801.05	$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 §134.600, 29 Texas Register 2349, effective March 14, 2004, requires preauthorization for inpatient hospital services.
4. 28 Texas Administrative Code §133.301, 25 *Texas Register* 2115, effective July 15, 2000, addresses retrospective review of medical bills.
5. 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.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 415-Unnecessary medical treatment and or services.
   - 517-Allowance based upon the invoice(s) detailing providers' cost.
   - 203-Disallowed: Included in another procedure/service.
   - 185-Allowance represents 85% of the provider's charge.

- Allowance reflects 75% of total billed charges.
- 223-Notice of medical payment dispute.
- This analysis was prepared utilizing the official medical fee guidelines for services rendered under the Texas Workers' Compensation Act.
- The allowances in this review are based on the QMEDTRIX determination of reasonable and customary charges for the region in which svcs were rendered.
- Unnecessary medical treatment and or service.
- Allowance based upon the invoice(s) detailing provider's cost.
- Disallowed: Documentation does not support charges.
- W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement.
- 42-Charges exceed our fee schedule or maximum allowable amount.
- 97-Payment is included in the allowance for another service/procedure.
- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.

8. Dispute M4-06-3910-01 History
   - Dispute was originally docketed as M5-06-0672-01. Upon receipt of requestor's withdrawal of medical necessity issues, the dispute was re-docketed as M4-06-3910-01.

Issues

1. Does a medical necessity issue exist in this dispute?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. 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 dispute supplemented the original MDR submissions. The division received supplemental positions as noted above. Positions were exchanged among the parties as appropriate. 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…" 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 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. According to the explanation of benefits, the respondent denied reimbursement in part based upon reason code "415.

   The requestor contends that reimbursement is due because preauthorization was obtained in accordance with 28 Texas Administrative Code §134.600 for dates of service January 27, 2005 through February 3, 2005. In support of their position, the requestor submitted a copy of a preauthorization report dated January 5, 2005 from the respondent's representative, Sedgwick CMS, preauthorizing a seven-day inpatient hospital stay.

   28 Texas Administrative Code §134.600 (f) states in part: "The carrier shall: (1) approve or deny requests for preauthorization or concurrent review based solely upon the reasonable and necessary medical health care required to treat the injury." Because preauthorization was obtained for a seven-day inpatient hospital stay; the respondent's denial of reimbursement based upon services not being medical necessary is not in accordance with 28 Texas Administrative Code §134.600 (f) (1).

In addition, 28 Texas Administrative Code §134.600 (f) states "The carrier shall: (7) not withdraw an approval once issued." Therefore, the respondent denial for services rendered on the preauthorized days is not in accordance with28 Texas Administrative Code §134.600 (f)(7). The respondent's denial for the eighth inpatient-day based upon medical necessity is in accordance with 28 Texas Administrative Code §134.600.

Furthermore, 28 Texas Administrative Code Rule §133.301(a) states, in pertinent part, that "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization." The documentation supports that the requestor in this case obtained preauthorization for dates of service January 27, 2005 through February 3, 2005.

On February 10, 2006, the requestor withdrew from the dispute the eighth inpatient day from the dispute; therefore, a medical necessity issue does not exist in this dispute.

2. 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, 28 Texas Administrative Code §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 §134.401(c)(6)(A)(v); therefore the audited charges equal $243,418.86. The Division concludes that the total audited charges exceed $40,000.00.
3. 28 Texas Administrative Code §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). Paragraph (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 extensive services" and further states that "independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." In its position, the requestor states:

   > The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay ('LOS') for workers' compensation inpatient admission is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

   The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, 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. 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 requestor's supplemental position statement asserts that:

   > "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the

median charge for workers' compensation surgeries of this type is $39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries; and third, it was necessary to purchase expensive implants for use in the surgery."

The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for similar spinal surgery services or admissions. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to similar spinal surgery services or admissions.

5. 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 Texas Administrative Code §134.401(c)(1) subtitled *Standard Per Diem Amount* and §134.401(c)(4) subtitled *Additional Reimbursements.* 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 seven surgical days and one ICU/CCU; therefore the standard per diem amounts of $1,118.00 and $1,560.00 apply respectively. The length of stay was eight days; however, documentation supports that the Carrier pre-authorized a length of stay of seven days in accordance with 28 Texas Administrative Code Rule §134.600. Consequently, the per diem rate allowed is $8,268.00 ($1,560 + $6,708.00) for the seven authorized days.

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

Itemized Statement Description	Units	Cost per Unit	Cost + 10%
Bone Graft Infuse	1	$4,900.00	$5,390.00
Screw Set Medtronic	6	$165.00	$1,089.00
Rod Medtronic	2	$378.00	$831.60
Screw Medtronic	2	$1,358.00	$2,987.60
Washer	2	$21.50	$47.30
Bone Graft Cortek	1	$4,800.00	$5,280.00
Screw Synthes	2	$29.25	$64.35
Strip Tricortical	1	$1,900.00	$2,090.00
Cortical Cancellous	1	$350.00	$385.00
Infuse BMP	1	$4,400.00	$4,840.00
Accell DBM-100 10CC	2	$1,495.00	$3,289.00
		TOTAL	$26,293.85

- 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 $215.00 for revenue code 380-Blood General; $1,232.00 for revenue code 382-Blood-Whole Blood; and $341.54 for revenue code 390-Blood Storage. 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 380, 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)(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 itemized statement finds that the requestor billed $488.75/unit for Epidural 0.1% 250ml, $302.85 unit for Thrombin 5,000 unit, and $289.00/unit for Dilaudid PCA 100ml. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $34,561.85. The respondent issued payment in the amount of $52,763.10. 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, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §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 Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		01/22/2014
Signature	Medical Fee Dispute Resolution Officer	Date
		01/22/2014
Signature	Healthcare Business Management Director	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.

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