Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ST LUKES BAPTIST HOSPITAL
17101 PRESTON TOAD SUITE 180-S
DALLAS TX 75248

Carrier's Austin Representative Box
19

Respondent Name
FACILITY INSURANCE CORP

MFDR Date Received
OCTOBER 15, 2008

MFDR Tracking Number
M4-09-3772-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated October 8, 2008: "As you are aware, 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…To be eligible for stop-loss payment, the *total audited charges* for a hospital admission must exceed $40,000, the minimum stop-loss threshold…DRG (Diagnostic Related Group) is a case-mix classification system that groups together patients who are similar clinically in terms of diagnosis and treatment, and in their consumption of hospital resources, thus allowing comparisons of resource use across hospitals with varying mixes of patients. Relative weights are standardized weights that represent the expected relative cost of treating the average case in a DRG…The claimant's procedures grouped to DRG 460..this procedure is more resource intensive than some other services, involving major joints…Review of the Medical Record substantiates the fact that [Claimant's] admission was extensive and costly. Postoperatively, he experienced a mildly diminished platelet count and had quite a bit of abdominal distention the first couple of days, and so his drain was not removed until late on the second day. After postoperative pain control and mobilization were achieved and the patient was deemed stable and safe, he was discharged on January 18, 2007."

Amount in Dispute: $23,404.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated December 17, 2008: "it is this carrier's position that:

- Texas Mutual Insurance Co. et al. v. Vista Community Medical Center, LLP, dba Vista Medical Center Hospital et al, No. 03-07-00682-CV, 2008 Tex. App. LEXIS 8602 upheld this Carrier's position that a provider must demonstrate that audited charges exceeded $40,000 and that the services provided were 'unusually costly' or 'unusually extensive' to allow application of the stop loss exception.
- The requestor did not support that the requester provided a legitimate argument supporting that the stay was unusual, costly, or lengthy. The DRG argument was put forth with incorrect codes and or descriptions, was not representative of the codes in effect for the date of service in dispute. Upon further of the average length of stay for DRG 460 which was 3.8 days, the 3 day stay in dispute was shorter than usual.
- It is this Carrier's position that abdominal distention and mild decrease in platelets does not support unusually costly or extensive services. Carrier's position is further supported by the early discharge.

- The Division of Workers' Compensation has identified that unnecessarily inflating costs in the system and may be contrary to overarching legislative intent that reimbursement be fair and reasonable as expressed in the Texas Labor Code 413.011 and 28 Texas Administrative Code 134.401(c)(6).
- The Division of Workers' Compensation has historically rejected reimbursement based on percent of charges as it provides little incentive for hospitals to contain costs and that methodology would not achieve the mandatory objective of achieving effective medical cost control.
- Reimbursement of THIS hospital bill at stop loss rate would not be fair or reasonable.
- The requester, Advance Practice Inc., is not a party to dispute.
- This is an incomplete request for dispute resolution."

Response Submitted by: UniMed Direct

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
November 15, 2007 through November 18, 2007	Inpatient Hospital Services	$23,404.88	$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, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, 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, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 150-Pmt adjusted because the payer deems the info submitted does not support this level of service. Additional information is supplied using remittance advice remarks codes whenever appropriate. Documentation required to review bill.
- 16-Claim/service lacks information which is needed for adjudication, operative report required.
- 50-These are non-covered services because this is not deemed a medical necessity by the payer. This service requires further documentation to substantiate medical necessity.
- W3-Additional payment made on appeal/reconsideration. Pd per diem method of the 1997 inpt fee guidelines. Stop Loss exception does not apply, services must be unusually extensive and costly. Documentation does not demonstrate this. see
- 97-Payment is included in the allowance for another service/procedure. The reimbursement for this line item has been included in the payment recommendation(s) for all covered services which are reported on another line or lines.
- W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. Reduced to fair and reasonable.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.

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 case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be 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 as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. A review of the explanation of benefits finds that initially the respondent denied reimbursement for the disputed services based upon reason code "50-These are non-covered services because this is not deemed a medical necessity by the payer. This service requires further documentation to substantiate medical necessity." Upon reconsideration, the respondent did not maintain this denial and issued payment of $14,354.00. As a result, 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, (A) (v) of that same section states "…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 carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $50,345.17. The Division concludes that the total audited charges exceed $40,000.
3. The requestor in its position statement presumes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. 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 extensive services." In addition to the charges exceeding $40,000, the requestor noted that this admission was unusually extensive because the DRG for this admission was grouped to 460. In support of their position, the requestor provided a Table comparing the relative weight of different DRGs. On this table, DRG 460 has the highest relative weight. The requestor notes that because DRG 460 has a higher relative weight, the hospitalization is unusually extensive. This categorization, that hospitalizations grouped to DRG 460 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 hospitalizations grouped to DRG 460 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 requestor presumes that because the bill exceeds $40,000, the stop loss method of payment should apply. 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 thereby affirming 28 Texas Administrative Code §134.401(c)(6) which 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 failed to demonstrate that the

particulars of the admission in dispute constitutes unusually costly services; therefore, the division finds that the requestor failed to meet 28 Texas Administrative Code §134.401(c)(6).

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) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *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.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. 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…" The length of stay was three days. The surgical per diem rate of $1,118 multiplied by the length of stay of three days results in an allowable amount of $3,354.00.
   - 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)."
   - The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	QTY.	Cost Per Unit	Cost + 10%
Interbody Fusion Sphere SS0012	1	$5,000.00	$5,500.00
Interbody Fusion Sphere SS0013	1	$5,000.00	$5,500.00
TOTAL	2		$11,000.00

   - 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 $371.52/unit for Thrombin Spray Kit 20,000 un. 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 $14,354.00. The respondent issued payment in the amount of $14,354.00. 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

		02/20/2014
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.