SOAH DOCKET NO. 453-03-3121.M4
MDR Tracking No. M4-02-4680-01

VISTA MEDICAL CENTER HOSPITAL,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
TEXAS MUTUAL INSURANCE CO.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

The Medical Review Division (MRD) of the Texas Workers' Compensation Commission[1] (Commission) denied the request for additional reimbursement filed by Vista Medical Center Hospital (Vista) for services it provided to a workers' compensation claimant during an inpatient hospital admission on August 25 through 31, 2001. Because Vista submitted neither medical records nor an itemized statement, MRD was unable to determine what services were rendered or what services could be deducted, such as personal items or those not related to the compensable injury. In this Decision and Order, the Administrative Law Judge (ALJ) finds that Vista is not entitled to additional reimbursement.

II. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

Attorneys Thomas B. Hudson, Jr., and Christopher H. Trickey represented TMIC, and attorney David F. Bragg represented Vista. The parties did not contest notice and jurisdiction.

This case was consolidated with Docket No. 453-03-2412.M4 for the purpose of resolving preliminary legal issues, and the order addressing those issues, Order No. 14 in Docket No. 453-04-2412.M4, was issued on November 22, 2005. Upon the parties' request, this case was abated from

[1] Effective September 1, 2005, the functions of the Commission were transferred to the newly-created Division of Workers' Compensation at the Texas Department of Insurance.

February 21, 2006, to April 4, 2007, when it was reinstated on the docket. Rather than having a contested case hearing, the parties elected to file written stipulations of fact and closing arguments. The parties attached documents to their stipulations, and those documents are admitted as Exhibit A. In addition, 36 numbered exhibits were admitted into evidence during the preliminary hearing. The record closed on July 9, 2007.

III. DISCUSSION

The claimant received a three-level fusion during the hospitalization at Vista. Vista charged a total of $158,847.66 for its services, and TMIC reimbursed Vista $27,932.50. Vista seeks an additional payment of $91,203.25, which is 75 percent of the amount Vista billed less the amount TMIC paid Vista. Other than the operative report attached to the parties stipulations,[2] there is no medical information in the file. Thus, with the exception of Vista's bill, there is no evidence regarding the care the claimant received at Vista before and after his surgery. The parties stipulated that Vista's services were not unusually costly or extensive in comparison to the services normally rendered to patients having the same surgery but were unusually costly or extensive in comparison to services rendered for simpler surgeries, such as hernia repair.

Vista charged $77,720 for implantables used in the claimant's surgery. Jim E. Bryant, Vista's Chief Executive Officer, testified that Vista marked up implantables four times their cost.[3] Based on Mr. Bryant's testimony, Vista's cost for implants would have been $19,430, and cost plus ten percent equals $21,373. TMIC argued the amount of Vista's markup was not fair and reasonable because Vista did not have to keep a large inventory of implantables on hand, and the hospital stored them for only a short time.

Mr. Bryant agreed that Vista received most implants on consignment.[4] The vendor took the implants, fusion cages, and pedicle screws to the facility the night before or at least three hours before the surgery, and the implants were kept in a sterile corridor.[5] Even so, Mr. Bryant asserted the

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[2] Ex. A, pp. TMIC 68-71.

[3] Ex. A, p. RD-27.

[4] Ex. 23, p. 25.

[5] *Id.*, pp. 26-27.

markup was reasonable because Vista had higher *labor costs* than other hospitals. Non-profit hospitals generally have 3.0 to 3.2 and for-profit hospitals have 2.8 to 3.0 full-time employees per occupied bed. Vista had 5.0 or 6.0 employees per occupied bed because patient needs at Vista were higher.[6] In addition to labor costs, Vista had non-labor costs for sterilizers, boilers, steam lines, filters, air conditioning, and electrical expenses.[7] To cover these costs, Vista not only marked up implantables four times the cost, Vista marked up medical and surgical supplies 500 percent for items costing more than $100, and 700 percent for items costing less than $100.[8] Every item, no matter what the cost to Vista, was charged to insurers at a minimum of $3, Mr. Bryant said.[9]

For this claimant, Vista billed room and board charges at the rate of $650 per day and also billed $500 for preoperative time; $14,000 for the use of an operating room; and $5,200 for the two hours the claimant spent in a recovery room. According to Mr. Bryant, Vista billed operating and recovery room minutes to cover *total salaries* per year.[10] But for the year 2001, Mr. Bryant could not state what Vista's total charges as a percent of its total costs (charge-to-cost ratio) were.[11]

TMIC did not dispute its obligation to pay Vista for services rendered to the claimant, but argued that Vista's charges exceeded the stop-loss threshold only because Vista inflated them. TMIC cited evidence of the amounts charged for the same diagnosis related group (DRG) at other Harris County hospitals. While Vista's charges in this case totaled $158,847.66, other Harris County hospitals charged an average of $47,975 for inpatient care for the same DRG (497).[12]

Vista contended that once the stop-loss threshold of $40,000 is reached, the provider qualifies for stop-loss reimbursement at 75 percent of the amount charged.[13] The provider need not meet any

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[6] *Id.*, pp. 56, 108.

[7] *Id.*, p. 43.

[8] *Id.*, pp. 62, 221.

[9] *Id.*, p. 66.

[10] *Id.*, p. 137.

[11] *Id.*, p. 137.

[12] Ex. A, p. RD-27, attachment 3, figure 3.

[13] 28 TAC § 134.401(b)(1)(H) and (c)(6)(A)(i).

additional requirement. In addition, even if Vista is required to prove its services were unusually extensive and costly, a back surgery is among the most complex surgeries performed. Thus, Vista has demonstrated that it should be reimbursed using the stop-loss method.

IV. ANALYSIS

Stop-loss reimbursement is allowed on a case-by-case basis for unusually extensive and costly services if a hospital's total audited charges exceed the $40,000 stop-loss threshold. When a provider qualifies for stop-loss reimbursement, the provider is to receive 75 percent of its total audited charges, less any amounts the carrier has already paid.[14] The ALJ finds that Vista did not meet its burden of proving it should be reimbursed using the stop-loss methodology because Vista failed to prove its services were unusually extensive and costly. The four-page operative report does not even state how long the surgery lasted, and other than Vista's bill, there is no information in the record regarding pre- or post-operative care Vista provided.

Further, Vista used its operating and recovery charges to cover total salaries for the year and then marked up implantables and other supplies from 400 to 700 percent to cover facilities and equipment costs and, again, to cover salaries. In addition, Vista billed separately for equipment use. For example, in its anesthesia charges, Vista billed $10,500 for anesthesia time, $1,500 for anesthesia equipment, and $101.25 for other anesthesia-related items.[15]

Other than its labor costs, which Vista apparently included twice in its cost-to-charge ratio, there was no evidence to indicate why Vista's charges were so much higher than other Harris County Hospitals. Mr. Bryant said patient needs at Vista were higher, but the record does not substantiate this assertion.

Based on the evidence, the ALJ finds that Vista should be reimbursed using the *per diem*

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[14] 28 TEX. ADMIN. CODE § 134.401(c)(6)

[15] This includes $32.00 for an anesthesia filter, $48 for an "anesthesia circuit," and $21.25 for an "ET tube." Ex. A, pp. RD -15

method. The parties stipulated that the correct amount of Vista's reimbursement is $27,932.50 if the *per diem* payment method applies to this admission. Accordingly, the ALJ finds that Vista is not entitled to any additional reimbursement.

V. FINDINGS OF FACT

1. A workers' compensation claimant was injured on _____, while working for an employer who carried workers' compensation insurance with Texas Mutual Insurance Company (TMIC).

2. On August 25, 2001, the claimant was admitted to Vista Medical Center Hospital (Vista) and underwent back surgery to treat his work-related injury.

3. The claimant's surgery involved a bilateral lumbar foraminotomy, nerve root decompression, and posterior lumber interbody fusion at vertebral levels L3-L4, L4-L5, and L5-S1, as well as bilateral laminectomies at levels L4-L5 and L5-S1.

4. The claimant experienced minimal blood loss during surgery and tolerated the procedure well.

5. Nothing unexpected or unusual occurred during the surgery or subsequent hospitalization.

6. The claimant was discharged from Vista on August 31, 2001.

7. Vista charged $158,847.66, for the services rendered to claimant from August 25 through 31, 2001, and TMIC's reimbursed Vista $27,932.50.

8. Vista received implants on consignment no earlier than the night before a surgery.

9. Vista marked up implantables four times its cost to cover what it said were higher labor costs.

10. Vista marked up medical and surgical supplies five times their cost if the item cost more than $100 and seven times their cost if the item cost less them $100.

11. Every item, no matter what the cost to Vista, was charged to insurers at a minimum of $3.

12. For this claimant, Vista billed room and board charges at the rate of $650 per day and also billed $500 for preoperative time; $14,000 for the use of an operating room; and $5,200 for the two hours the claimant spent in a recovery room.

13. The operating room and recovery room charges were calculated to cover labor costs.

14. There was no evidence of what Vista's total charges as a percent of its total costs (charge-to-cost ratio) were.

15. Vista's services were not unusually costly and extensive in comparison to the services

normally rendered to patients having the same surgery.

16. The parties stipulated that, if the *per diem* payment method described in 28 TAC § 134.401 applies to this admission, the correct amount of reimbursement is $27,932.50, which is the amount TMIC has already paid Vista.

17. On July 26, 2002, Vista filed a request with the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) asking that TMIC be ordered to reimburse Vista an additional $91,203.25, which is 75 percent of the total amount billed, less the amount TMIC has paid.

18. In a decision dated March 28, 2003, MRD denied the request for additional reimbursement, and Vista requested a contested case hearing before the State Office of Administrative Hearings (SOAH).

19. Notice of the hearing on Vista's appeal, dated May 16, 2003, was sent to both parties. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

20. On August 13, 2003, this case was consolidated with Docket No. 453-03-2412.M4, for the purpose of resolving threshold legal issues.

21. Order No. 14 in Docket No. 453-03-2412.M4 was issued November 22, 2005. The order resolved legal issues pertaining to this case and advised the parties to request hearing dates.

22. Based upon the parties' joint request, this docket was abated from February 21, 2006, to April 4, 2007, when the case was reinstated on the docket.

23. After the case was reinstated on the docket, the parties elected to file written stipulations of fact and closing arguments, rather than having a contested case hearing.

24. Attorneys Thomas B. Hudson, Jr., and Christopher H. Trickey represented TMIC, and attorney David F. Bragg represented Vista.

VI. CONCLUSIONS OF LAW

1. The Commission had, and the Division of Workers' Compensation at the Texas Department of Insurance has, jurisdiction over this matter pursuant to § 413.031 of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. ch. 401 *et seq*. (Vernon's 2003).

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003 (Vernon's 2003).

3. Vista had the burden of proof in this case. 28 TEX. ADMIN. CODE (TAC) § 148.14.

4. The stop-loss method is an independent reimbursement methodology established to ensure

fair and reasonable compensation to the hospital for unusually costly and extensive services rendered during treatment to an injured worker. 28 TAC § 134.401(c)(6).

5. Vista did not meet its burden of proving its services were unusually extensive or costly.

6. Vista should be reimbursed using the *per diem* method. 28 TAC § 134.401(c).

7. TMIC has appropriately reimbursed Vista for the claimant's hospitalization. 28 TAC § 134.401(c).

8. Vista is not entitled to additional reimbursement.

ORDER

IT IS, THEREFORE, ORDERED that Vista Medical Center Hospital's request for additional reimbursement is denied.

SIGNED September 7, 2007.

SARAH G. RAMOS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS