SOAH DOCKET NO. 453-05-7695.M4
MDR NO. M4-05-5996-01

VISTA MEDICAL CENTER HOSPITAL, Petitioner	§	**BEFORE THE STATE OFFICE**
	§	
	§	
V.	§	**OF**
	§	
INSURANCE COMPANY OF THE STATE OF PA., Respondent	§	
	§	
	§	**ADMINISTRATIVE HEARINGS**
	§	

DECISION AND ORDER

Vista Medical Center Hospital (Provider) requested a hearing on a decision by the Medical Review Division (MRD) of the Texas Department of Insurance, Division of Workers' Compensation (Division)[1] ordering additional reimbursement for a hospital stay provided to Claimant, an injured worker. Provider argued that reimbursement for this admission should be based on the Stop-Loss Exception to the per diem reimbursement methodology contained in the 1997 Acute Care Inpatient Hospital Fee Guideline (1997 ACIHFG).[2] The Administrative Law Judge (ALJ) finds the Stop-Loss Exception should be followed in this proceeding. Accordingly, Insurance Company of the State of Pa. (Carrier) is ordered to pay additional reimbursement in the amount of $56,600.88, plus any applicable interest.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on May 20, 2005. Provider filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the parties. The hearing convened

---

[1] Effective September 1, 2005, the legislature dissolved the Texas Workers' Compensation Commission (Commission) and created the Division of Workers' Compensation within the Texas Department of Insurance. Act of June 1, 2005, 79th Leg., R.S., ch. 265, § 8.001, 2005 Tex. Gen. Laws 469, 607. This Decision and Order refers to the Commission and its successor collectively as the Division.

[2] The 1997 ACIHFG established a general reimbursement scheme for all inpatient services provided by an acute care hospital for medical and/or surgical admissions using a service-related standard per diem amount. 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 28 TEX. ADMIN. CODE (TAC) § 134.401(c). This independent reimbursement mechanism, the Stop-Loss Method or Stop-Loss Methodology, is sometimes referred to as the Stop-Loss Exception or the Stop-Loss Rule.

and concluded on April 10, 2008.[3] The record closed that same day.

II. DISCUSSION

A. Factual Overview

The basic facts were uncontested. Claimant sustained a compensable injury and was admitted to Provider, where Claimant underwent treatment. After Claimant was discharged from the hospital, Provider submitted a bill to Carrier in the amount of $167,560.17 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. To date, Carrier has paid $54,204.40.

B. Issues

1. Summary of Positions and ALJ's Decision

In summary, the parties' positions and ALJ's findings are as follows:

[3] Beginning in 2003, the Division began referring a significant number of ACIHFG cases to SOAH. Between 2003 and August 31, 2005, approximately 885 ACIHFG cases were referred to SOAH for contested case hearings on issues including the Stop-Loss Exception, audits, and the reimbursement of implantables. In order to efficiently and economically manage this growing number of cases, SOAH in late 2004 and early 2005 began to join the cases into a Stop-Loss Docket, and the cases were abated. By the close of the 2005 regular legislative session, SOAH realized a finite, but still unknown; number of Stop-Loss cases would be referred to SOAH by the Division through August 31, 2005.

	MRD	Provider	Carrier	ALJ
Charges	$167,560.17	$167,560.17	$167,560.17	**$167,560.17**
Disputed Post-Audit Charges	$127,671.27	$167,560.17	$147,620.15[4]	**$76,785.17**[5]
Reimbursement Methodology	modified Stop-Loss[6]	x 75%	unknown	**x 75%**[7]

[4] Provider's billed charges were audited by CorVel Corporation using CorVel's MedCheck Select. CorVel's audit reductions, excluding reductions regarding usual and customary charges (Code Legend 1), totaled $17,389.95. To this figure Carrier added an additional reduction of $2,556.07 for charges during the last two days of the hospital stay that it contended were not preauthorized. Carrier contended total audit reductions, excluding reductions regarding usual and customary charges, were $19,940.02.

[5] As noted below, the ALJ finds that all eight days of the hospital stay were preauthorized and does not deduct $2,556.07 for the last two days' charges. Although it appears from other evidence in the record that an Explanation of Benefits (EOB) was sent to Provider that used denial codes "F" and "M," that EOB is not in the evidentiary record. A September 17, 2003 EOB on Resubmission denies payment for $167,560.17 in billed charges with a denial code "O" ("Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid according (sic) to state fee guidelines and/or state rules and regulations"). The Resubmission EOB appears to be in response to an August 12, 2003 letter from Provider's Collection Department stating that it had received partial payment of $28,847.75 from Carrier and that Carrier had used "denial codes 'M and F,' stating, 'The following adjustment has been made to the invoice following hospital audit.' 'Reduced to fair and reasonable.' And 'Submitted services were repriced in accordance with state per diem guidelines."

Provider contended it did not receive the CorVel audit. The ALJ finds that Provider did not receive the CorVel audit prior to the request for dispute resolution. The document is not in Provider's records. The CorVel audit is not mentioned in the correspondence regarding the initial EOB, the partial payment, the Resubmission EOB, or any other contemporaneous documents. The earliest mention of the CorVel audit is in the May 20, 2005 MRD Decision by reference to a February 25, 2004 letter submitted to MRD by Carrier after the request for dispute resolution was filed by Provider. The CorVel audit document does not contain any date or other reference that denotes when the audit was conducted or when the original document was prepared. There is no reference to transmittal of the document to Provider. There is no evidence in the record that shows Provider was put on notice of the CorVel audit and had an opportunity to answer the reasons for payment denial codes prior to Provider requesting dispute resolution. Therefore, the reasons for denial in the CorVel audit are not available to Carrier. Pursuant to 28 TAC § 133.307(j)(2), any defense or reason for denial of a claim not asserted by a carrier before a request for medical dispute resolution may not be considered at the hearing before SOAH, whether or not it arises out of an audit.

Provider only placed $76,785.17 of the total billed charges into dispute resolution. Of the $28,847.75 paid by Carrier, only $988.00 was paid toward disputed charges; $27,859.75 was paid for charges Provider elected not to dispute.

[6] MRD determined that the Stop-Loss Exception did apply since the admission did involve "unusually extensive services." Although the hospital stay lasted eight days, MRD ordered reimbursement based on six days. MRD stated that "the last 2 days were not preauthorized" and did not recommend payment for $2,556.07 in charges for April 13 and 14, 2003. MRD then quoted extensively from a February 25, 2004 letter from Hartford, letter not in evidence in this case, and noted that Provider "did not submit convincing evidence to support (its) position that the audit reduction of $39,888.90 was inappropriate." MRD allow Carrier's reductions for usual and customary although such reductions are not consistent with the Stop-Loss Exception. MRD found that Carrier had paid $988.00 and owed an additional $25,356.65. Following the MRD decision, Carrier apparently paid an additional $25,366.65 as follows: $12,075.00 for OR service charges; $10,260.00 for anesthesia charges; $1,823.50 for pulmonary function charges; and $1,198.15 for cardiology charges.

[7] The Stop-Loss Threshold was met in this case and the reimbursement for the preauthorized 8-day hospitalization should be calculated according to the Stop-Loss Exception. Reduction of charges to Carrier's fair and reasonable allowance is not consistent with the Stop-Loss Exception. The additional 2-day hospital stay was preauthorized by Carrier as evidenced in Provider Ex. 1, p. 41.

	MRD	Provider	Carrier	ALJ
Reimbursement Amount	$26,344.65	$125,670.13	$110,715.11	**$57,588.88**
Less Payment	($988.00)	($54,204.40)[8]	($54,204.40)	**($988.00)**
Balance Due Provider	$25,356.65	$71,465.73	$56,510.71	**$56,600.88**

2. Background

When a hospital's total audited bill is greater than $40,000, the Division's Stop-Loss Exception applies, and the hospital is reimbursed at 75% of its total audited bill. The purpose of the Stop-Loss Methodology is "to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker."[9] The following legal issues in this case were decided by a SOAH En Banc Panel[10] (En Banc Panel), and those determinations are incorporated herein. Legal arguments related to these issues will not be addressed, other than in the Conclusions of Law.

1. The ALJs conclude that a hospital's post-audit usual and customary charges for items listed in 28 TAC § 134.401(c)(4) are the audited charges used to calculate whether the Stop-Loss Threshold has been met for a workers' compensation admission. The ALJs decline to adopt the Carriers' argument to use the carve-out reimbursement amounts in § 134.401(c)(4) as audited charges, and they decline to adopt the Division's argument to use a fair-and-reasonable amount as determined by a carrier in its bill review as audited charges.

2. The ALJs find that when the Stop-Loss Methodology applies to a workers' compensation hospitalization, all eligible items, including items listed in § 134.401(c)(4), are reimbursed at 75% of their post-audit amount. Items listed in § 134.401(c) (4) are not reimbursed at the carve out amounts provided in that section when the Stop-Loss Methodology is applied.

3. The ALJs conclude that any reasons for denial of a claim or defenses not asserted by a Carrier before a request for medical dispute resolution may not be considered, whether or not they arise out of an audit. The ALJs also conclude that Carriers' audit rights are not limited by § 134.401(c) (6) (A) (v) when the Stop-Loss Methodology applies. In such cases, carriers may audit in accordance with § 134.401(b) (2) (c).

---

[8] The parties stipulated that Carrier paid $54,204.40. The ALJ notes that this corresponds to an initial payment of $28,847.55 and a subsequent payment of $25,356.65.

[9] 28 TAC § 134.401(c) (6).

[10] En Banc Panel Order in Consolidated Stop-Loss Legal Issues Docket, SOAH Docket No. 453-03-1487.M4 (Lead Docket), issued January 12, 2007.

4. The ALJs find that a hospital establishes eligibility for applying the Stop-Loss Methodology under § 134.401(c) (4) when total eligible amounts exceed the Stop-Loss Threshold of $40,000. There is no additional requirement for a hospital to establish that any or all of the services were unusually costly or unusually extensive.[11]

Finally, in reply to a request for clarification, the En Banc Panel found that when referring to a hospital's usual and customary charges, the rules are referring to the hospital's own usual and customary charges and not to charges that are an average or median of other hospitals' charges.[12] Provider charged its usual and customary charges for the items and services provided.

In summary, the ALJ concludes that the Stop-Loss Threshold was met in this case and that the amounts in dispute should be calculated accordingly.

III. FINDINGS OF FACT

1. Claimant sustained a compensable injury in the course and scope of employment; the employer had coverage with Insurance Company of the State of Pa. (Carrier).

2. Vista Medical Center Hospital (Provider) provided medical treatment to Claimant for the compensable injury.

3. Provider submitted itemized billing totaling $167,560.17 for services provided to Claimant.

4. The $167,560.17 billed was Provider's usual and customary charges for these items and treatments.

5. Carrier issued payments of $54,204.40 to Provider for the services in question.

6. Carrier denied further reimbursement to Provider.

7. Provider requested Dispute Resolution Services from the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission).

8. Effective September 1, 2005, the legislature dissolved the Commission and created the Division of Workers' Compensation within the Texas Department of Insurance. The Commission and its successor are collectively referred to as the Division.

---

[11] Because of a typographical error, the En Banc Panel's decision incorrectly cites § 134.401(c)(4) rather than § 134.401(c)(6) as the applicable rule.

[12] Letter from ALJ Catherine C. Egan dated February 23, 2007.

9. MRD issued its Findings and Decision holding that additional reimbursement was owed Provider.

10. Provider timely filed a request for a contested case hearing on the MRD's decision.

11. All parties were provided not less than 10-days notice of hearing and of their rights under the applicable rules and statutes.

12. On April 10, 2008, Administrative Law Judge Howard S. Seitzman convened a hearing on the merits at the hearing facilities of the State Office of Administrative Hearings (SOAH) in Austin, Texas. Carrier and Provider were present and represented by counsel. The Division did not participate in the hearing. The hearing concluded and the record closed that day.

13. Provider submitted only $76,785.17 in billed charges to MRD for dispute resolution and the Carrier's payment corresponding to these disputed charges totaled $988.00.

14. Provider's total audited charges under § 134.401(c) (6) (A) (v) are $76,785.17, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

15. Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $57,588.88. After deduction of Carrier's prior payment of $988.00, Provider is entitled to additional reimbursement of $56,600.88, plus any applicable interest, under the Stop-Loss Methodology.

IV. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §§ 402.073 and 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely requested a hearing, as specified in 28 TEX. ADMIN. CODE (TAC) § 148.3.

3. Proper and timely notice of the hearing was provided to the parties in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. Provider had the burden of proof in this proceeding pursuant to 28 TAC § 148.21(h) and (i).

5. All eligible items, including the items listed in 28 TAC § 131.401(c)(4), are included in the calculation of the $40,000 Stop-Loss Threshold.

6. In calculating whether the Stop-Loss Threshold has been met, all eligible items are included at the hospital's usual and customary charges in the absence of an applicable MARS or a specific contract.

7. The carve-out reimbursement amounts contained in 28 TAC § 134.401(c)(4) are not used to calculate whether the Stop-Loss Threshold has been met.

8. When the Stop-Loss Methodology applies to a workers' compensation admission, all eligible items, including items listed in 28 TAC § 134.401(c)(4), are reimbursed at 75% of their post-audit amount.

9. Under the Stop-Loss Methodology, items listed in 28 TAC § 134.401(c)(4) are not reimbursed at the carve-out amounts provided in that section when the Stop-Loss Methodology applies.

10. Carriers' audit rights are not limited by 28 TAC § 134.401(c) (6) (A) (v) when the Stop-Loss Methodology applies. In such cases, carriers may audit in accordance with 28 TAC § 134.401(b) (2) (C).

11. Pursuant to 28 TAC § 133.307(j)(2), any defense or reason for denial of a claim not asserted by a carrier before a request for medical dispute resolution may not be considered at the hearing before SOAH, whether or not it arises out of an audit.

12. A hospital, Provider in this case, establishes eligibility for applying the Stop-Loss Methodology under 28 TAC § 134.401(c) (6) when total eligible charges exceed the Stop-Loss Threshold of $40,000. There is no additional requirement for a hospital to separately establish that any or all of the services were unusually costly or unusually extensive.

13. The Stop-Loss Methodology applies to this case.

14. The February 17, 2005 Staff Report (Staff Report) by MRD Director Allen C. McDonald, Jr., is not consistent with the Stop-Loss Rule, 28 TAC § 134.401(c)(6), and is not consistent with the Division's prior interpretation of the rule that the $40,000 Stop-Loss Threshold alone triggered the application of the Stop-Loss Methodology.

15. The Staff Report is not consistent with the Stop-Loss Rule, the preambles to the Stop-Loss Rule published in the *Texas Register*, or MRD decisions issued prior to February 17, 2005.

16. The Staff Report has no legal effect in this case.

17. Applying the Stop-Loss Methodology in this case, Provider is entitled to total reimbursement of $57,688.88.

18. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $988.00 of this amount.

19. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $56,600.88, plus any applicable interest.

ORDER

It is hereby **ORDERED** that Insurance Company of the State of Pa., reimburse Vista Medical Center Hospital the additional sum of $56,600.88, plus any applicable interest, for services provided to Claimant. All relief not expressly granted herein is **DENIED**.

SIGNED June 6, 2008.

____

HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS