SOAH DOCKET NO. 453-03-1487.M4
TWCC MDR NO. M4-02-3850-01

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

DECISION AND ORDER

Hartford Casualty Insurance Company (Carrier) requested a hearing on a decision by the Medical Review Division (MRD) of the Texas Department of Insurance, Division of Workers' Compensation (Division) ordering additional reimbursement to Vista Medical Center Hospital (Provider) for a hospital stay provided to Claimant, an injured worker. The decision ordered Carrier to reimburse Provider an additional $72,852.90. The Carrier argued it correctly reimbursed Provider based on the standard per diem plus carve-outs reimbursement methodology contained in the 1997 Acute Care Hospital Fee Guideline. The Administrative Law Judges (ALJs) find the stop-loss methodology should be followed in this proceeding. Accordingly, and considering other minor adjustments, additional reimbursement in the amount of $69,751.58 is ordered.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

The MRD issued its decision on November 14, 2002. Petitioner filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the parties, and the hearing convened and concluded on September 15, 2004. Prior to issuance of a decision, the case was joined with other stop-loss cases for reasons of efficiency.[1]

[1] 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.

II. DISCUSSION

A. Factual Overview

The basic facts were uncontested. Claimant sustained a compensable injury and was admitted to Provider, where she underwent treatment. After Claimant was discharged from the hospital, a bill was submitted to Carrier in the amount of $136,632.37 based on its usual and customary charges for the inpatient stay and surgical procedure. The bill included $51,328.00 for surgical implantables. To date, Carrier has paid $30,484.25.

B. Issues

1. Summary of Positions and ALJs' Decision

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

	MRD	Provider	Carrier	ALJs
Total Bill	137,782.87	$137,782.87	$137,782.87	**137,782.87**
Audit Adjustments	0	0	(106,866.24)	**(4,823.09)**
Subtotal	137,782.87	137,782.87	30,916.63	**132,958.97**
75% Stop Loss Methodology	X0.75	X 0.75	applied standard per diem rate [2]	**X 0.75**
Reimbursement Amount	103,337.15	103,337.15	30,484.25	**99,719.23**
Less Payment	(30,484.25)	(30,484.25)	(30,484.25)	**(30,484.25)**
Balance Due / (Refund Due)	72,852.90	$72.852.90	0	**69,234.98**

[2] Carrier calculated the reimbursement on the per diem calculation (14 days @ $1118.00 per day for $15,653), plus the cost of implantables as cost plus 10% (13,854.33), plus the fair and reasonable cost of blood ($977.92) for a total reimbursement of $30,484.25. Because this amount is below the $40,000 threshold for stop-loss, Carrier suggest the stop-loss rules do not apply.

2. Background

When a hospital's total audited bill is greater than $40,000, the Commission's stop-loss methodology 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."[3] The following legal issues in this case were decided by a SOAH en banc panel[4] (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 reimbursement 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 reimbursement 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 reimbursement methodology applies. In such cases, carriers may audit in accordance with § 134.401(b)(2)(C).

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[3] 28 TEX. ADMIN. CODE (TAC) § 134.401(c)(6).

[4] En Banc Panel Order in Consolidated Stop Loss Legal Issues Docket, issued January 12, 2007.

4. The ALJs find that a hospital establishes eligibility for applying the stop-loss reimbursement 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.

Finally, in reply to a request for clarification, the En Banc Panel found that the 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.[5] Accordingly, Carrier's attempt to use the paper audit, performed by Corvel Corporation in this case to reduce Provider's charges to the median charges of other hospitals in the region, is not applicable as used. Provider is required to charge its usual and customary charges, and Carrier failed to prove any of the charges assessed were not Provider's usual charges for that particular item or service.

However, the audit was also used for other, relevant purposes. The appropriate issues to audit include those described in §134.401(c)(6)(A)(v) and (b)(2)(C). The more limited subsection (c)(6)(A)(v) provides for auditing personal items (e.g., telephone, television), and if an on-site audit is performed, charges for services which are not documented as rendered during the admission may be deducted. Items and services which are not related to the compensable injury may also be deducted. The broader subsection (b)(2)(C) provides that all charges submitted are subject to audit as described in the Commission's rules. The rules address auditing at 28 TEX. ADMEN. CODE § 134.401(b)(2)(C), which includes examination for:

(1) compliance with the fee guidelines established by the Commission;
(2) compliance with the treatment guidelines established by the Commission;
(3) duplicate billing;
(4) upcoding and/or unbundling;
(5) billing for treatments and services unrelated to the compensable injury;
(6) billing for services not documented or substantiated, when documentation is required in accordance with Commission fee guidelines or rules in effect for the dates of service;

[5] Letter from dated February 23, 2007.

(7) accuracy of coding in relation to the medical record and reports;
(8) correct calculations; and/or
(9) provision of unnecessary and/or unreasonable treatment(s) and/or services.

3. Other Issues Specific to This Case

In its closing statement, Carrier focused on the legal issues discussed above and argued that $42,644.51 should be disallowed. This amount was identified in the Corvel audit as above usual and customary charges for the geographic area or for a similar, related reason. As noted by the En Banc Panel, "usual and customary" does not include a comparison to regional billing, thus all $42,644.51 should be allowed.

While Carrier did not brief other audit issues, the ALJs identified and will address two issues based on the Covel audit and the testimony of Christy J. Averitt, a registered nurse and team leader of the medical review department for Corvel Corporation of Fort Worth.[6] The audit found $4,135.09 should be disallowed for "unbundled from basic charge," and further that $1,088 should be disallowed as "billing in error, additional documentation required." After reviewing the audit and relevant testimony, the ALJs conclude that the greater weight of evidence in this record suggests $4,135.09 should be disallowed for improper unbundling. Ms. Averitt explained that the Provider improperly unbundled charges for anaesthesia equipment, which is a capital cost improperly unbundled from the anaesthesia charge. She gave numerous examples where Provider had improperly included costs for capital equipment that is be used for numerous patients. According to Ms. Averitt, the costs for capital equipment should be bundled with the charge for the service performed. She further identified numerous items improperly unbundled from the general room charge, including exam gloves, tongue blades, and alcohol preparation pads. The ALJs accordingly conclude that $4,135.09 should be disallowed for improper unbundling.

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[6] For an issue to be relevant to this proceeding, it must have been raised by the Carrier as a reason for denial of a claim before a request for medical dispute resolution was submitted. Ms. Averitt mentioned new reasons for disallowing some charges during her testimony or provided new coding for some denials. Her comments to this effect are not relevant to this proceeding and, thus, are not discussed herein.

The ALJs found that Carrier met its burden of proving $688 of the $1,088 disallowed as billing in error should not be reimbursed. Dual applicators accounted for $400 of the $1,088 disallowed, and Ms. Averitt described this only as a potential error and did not prove the billing was, in fact, in error. She was unsure as to what the term "dual applicator" referred to, so she could not testify that it was, in fact, billed in error. However, she did testify that the remaining $688 charged for a template was in error as it is used for a different type of surgery—hip or knee—to measure for prosthetic devices or implants, but not for a back surgery.

In summary, the ALJs conclude that the stop-loss threshold was met in this case and that the amounts due should be calculated accordingly. Further, the ALJs determined that $4,135.09 should be disallowed for improper unbundling, but that the entire remainder of Provider's bill is owed by carrier, in the amount of $69,751.58.

III. FINDINGS OF FACT

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

2. Vista Medical Center Hospital (Provider) provided medical treatment to Claimant for her workers' compensation injury.

3. Provider submitted itemized billing totaling $137,782.87 for the services provided to Claimant for the treatment in issue.

4. Provider's bill included charges in the amount of $51,328 for surgical implantables used to treat Claimant

5. The $137,782.87 billed was Provider's usual and customary charges for these items and treatments.

6. Carrier did not perform an on-site audit of the bill but did conduct a paper audit performed by Corvel Corporation.

7. $4,135.09 of the billed amount is disallowed as an improper unbundling from the basic charge.

8. $688 of the billed amount is disallowed as billing in error.

9. Carrier has issued a payment of $30,484.25 to Provider for the services in question.

10. Carrier denied further reimbursement to Provider.

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

12. MRD issued its Findings and Decision, ordering Carrier to remit an additional $72,852.90 plus interest to Provider.

13. Carrier timely filed a request for a contested case hearing on the MRD's decision.

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

15. On September 15, 2004, ALJ Cassandra Chruch convened a hearing on the merits at the SOAH hearing facilities in Austin, Texas. Carrier and Provider were present and represented by counsel. The Commission did not participate in the hearing. The hearing concluded and the record closed May 1, 2007.[7]

16. Provider's total audited charges under § 134.401(c)(6)(A)(v) are $132,958.97, which allows Provider to obtain reimbursement under the Texas Workers' Compensation Commission's stop-loss reimbursement methodology.

17. Under the stop-loss methodology, Provider is entitled to total reimbursement of $99,719.23. After deduction of Carrier's prior payment of $30,484.25, the Hospital is entitled to additional reimbursement of $69,234.98.

IV. CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation[8] has jurisdiction to decide the issue presented, pursuant to TEX. LAB. CODE ANN. § 413.031.

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[7] The record was re-opened for the decision of the En Banc Panel and is closed with the issuance of the Proposal for Decision.

[8] Effective September 1, 2005, the legislature dissolved the Texas Workers' Compensation 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.

2. 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.

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

4. Proper and timely notice of the hearing was provided to the parties according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Carrier had the burden of proof in this proceeding pursuant 28 TAC § 148.21(h) and (i).

6. 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.

7. 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.

8. 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.

9. When the stop-loss reimbursement 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.

10. 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 reimbursement methodology applies.

11. Carriers' audit rights are not limited by 28 TAC § 134.401(c)(6)(A)(v) when the stop-loss reimbursement methodology applies. In such cases, carriers may audit in accordance with 28 TAC § 134.401(b)(2)(C).

12. 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.

13. A hospital, Provider in this case, establishes eligibility for applying the stop-loss reimbursement methodology under 28 TAC § 131.401(c)(4) 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.

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 for the cases subject to this order.

17. Applying the stop-loss methodology in this case, Provider is entitled to total reimbursement of $99,719.23.

18. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $30,484.25.

19. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $69,234.98, plus interest.

ORDER

It is hereby ORDERED that Hartford Casualty Insurance Company reimburse the Vista Medical Center Hospital the additional sum of $69,234.98, plus interest, for services provided to Claimant.

SIGNED May 2, 2007.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

HOWARD SEITZMAN
TOMMY BROYLES
ADMINISTRATIVE LAW JUDGES