SOAH DOCKET NO. 453-05-5497.M4
MDR NO. M4-03-9278-01

VISTA MEDICAL CENTER HOSPITAL, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
TRAVELERS INDEMNITY COMPANY, **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] regarding additional reimbursement to Provider for a hospital stay provided to an injured worker (Claimant). 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 Judges (ALJs) hold Provider is not entitled to additional reimbursement from Travelers Indemnity Company (Carrier) for the services provided to Claimant because the disputed services were for conditions that were not part of the compensable injury.

[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.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on March 9, 2005. Carrier and Provider both filed timely and sufficient requests for hearing. Notice of the hearing was appropriately issued to the parties. The hearing convened and concluded on October 23, 2007.[3] On November 27, 2007, Carrier filed a Motion to Stay Proceedings (Motion).[4] A copy of a June 14, 2005 Final Judgment in Cause No. 2003-57365 from the 151st District Court of Harris County, Texas (June 14, 2005 Final Judgment), accompanied the Motion. By Order dated November 29, 2007, the proceedings were stayed and the record was reopened for the admission of the Motion and the June 14, 2005 Final Judgment. The record remained open until January 23, 2008, to allow Provider an opportunity to respond to the Motion and to the June 14, 2005 Final Judgment. Provider timely filed its response and the record closed on January 23, 2008.

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 $182,357.85,[5] based on Provider's usual and customary charges for the inpatient stay and surgical procedure.

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[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.

[4] In the Motion, Counsel for Carrier stated he was not aware of the June 14, 2005 Final Judgment at the time of the SOAH Hearing and that he was not provided a copy of the June 14, 2005 Final Judgment until November 26, 2007.

[5] Although the billed charges were originally $182,632.85, the parties agreed to reduce the amount to $182,357.85 to account for a duplicate charge.

To date, Carrier has paid $36,727.97.

Claimant's operation at Provider's facility was for a herniated lumbar disc at L4-5 and L5-S1. A June 19, 2003 Decision and Order issued by the Division (June 19, 2003 Division Decision) held that Claimant sustained a compensable lumbar spine injury on January 23, 2002, and that Claimant's compensable injury included "moderate desiccation of the L4-5 and L5-S1 discs with moderate loss in height in L5-S1 and central posterior bulge at the L5-S1 level becoming of protrusion severity along the right lateral margin." Following the June 19, 2003 Division Decision, the MRD issued its March 9, 2005 Findings and Decision.

On October 14, 2003, Carrier filed a petition in district court seeking to reverse the June 19, 2003 Division Decision. A March 24, 2005 trial resulted in the June 14, 2005 Final Judgment. The District Court's June 14, 2005 Final Judgment finds:

> that the compensable injury does not extend to the MRI finding taken on April 16, 2002 (moderate desiccation of the L4-5 and L5-S1 discs with moderate loss in height in L5-S1 and central posterior bulge at the L5-S1 level becoming of protrusion severity along the right lateral margin) and /or lumbar herniations.

B. Issues

1. Summary of Positions and ALJs' Decision

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

	MRD	**Provider**	**Carrier**	**ALJs**
Charges	$182,357.85	$182,357.85	$182,357.85	**$182,357.85**
Reimbursement Methodology	per diem	x 75%	modified Stop-Loss[6]	**N/A**

[6] Carrier paid 75 percent for many, but not all, of the billed charges. Carrier paid $0.00 for implantables and an OR/Minor charge and paid approximately 32 percent of billed charges for med/surg supplies.

Reimbursement Amount	$30,675.50[7]	$136,768.38	$36,727.97	**N/A**
Less Payment	($36,727.97)	($36,727.97)	($36,727.97)	**($36,727.97)**
Balance Due Provider	$0.00	$100,040.41	$0.00	**$0.00**[8]

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.

3. 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

[7] MRD determined that the Stop-Loss Exception did not apply since the admission did not involve "unusually extensive services." MRD calculated reimbursement based on the per diem methodology (5 days " $1,118.00 per day , $5,590.00). MRD also noted that the hospital was entitled to reimbursement of $25,085.50 for implantables at cost plus 10%.

[8] The ALJs conclude no balance is owed Provider because there has been a final adjudication that the condition for which Claimant received services from Provider is a condition unrelated to the compensable injury. Even though the service was preauthorized, Carrier is not liable to Provider when there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury. 28 TAC § 134.600(c), now 28 TAC § 134.600(d). Further, TEX. LAB. CODE ANN. § 408.021(a) provides that an employee must sustain a compensable injury to be entitled to all health care reasonably required by the nature of the injury as and when needed.

[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.

Division's argument to use a fair-and-reasonable amount as determined by a carrier in its bill review as audited charges.

4. 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.

5. 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).

6. 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 particular items or service.

In summary, the ALJs conclude that Provider has not met its burden of showing it is entitled to additional reimbursement.

III. FINDINGS OF FACT

1. Claimant sustained an injury in the course and scope of his employment; his employer had coverage with Travelers Indemnity Company (Carrier).

[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.

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

3. Provider submitted itemized billing totaling $182,357.85 for the services provided to Claimant for the treatment in issue.

4. Provider's bill included charges in the amount of $108,999.00 for surgical implantables used to treat Claimant.

5. Carrier has issued payments of $36,727.97 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.

9. MRD issued its Findings and Decision, holding that no additional reimbursement was owed by Carrier.

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 October 23, 2007, Administrative Law Judges Howard S. Seitzman and Tommy L. Broyles 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 initially closed that same day.

13. On November 27, 2007, Carrier filed a Motion to Stay Proceedings (Motion). A copy of a June 14, 2005 Final Judgment in Cause No. 2003-57365 from the 151st District Court of Harris County, Texas (June 14, 2005 Final Judgment), accompanied the Motion. By Order dated November 29, 2007, the proceedings were stayed and the record was reopened for the admission of the Motion and the June 14, 2005 Final Judgment. The record remained open until January 23, 2008, to allow Provider an opportunity to respond to the Motion and to the June 14, 2005 Final Judgment. Provider timely filed its response and the record closed on January 23, 2008.

14. Claimant's operation at Provider's facility was for a herniated lumbar disc at L4-5 and L5-S1.

15. A June 19, 2003 Decision and Order issued by the Division (June 19, 2003 Division Decision) held that Claimant sustained a compensable lumbar spine injury on January 23, 2002, and that Claimant's compensable injury included "moderate desiccation of the L4-5 and L5-S1 discs with moderate loss in height in L5-S1 and central posterior bulge at the L5-S1 level becoming of protrusion severity along the right lateral margin."

16. Following the June 19, 2003 Division Decision, the MRD issued its March 9, 2005 Findings and Decision.

17. On October 14, 2003, Carrier filed a petition in district court seeking to reverse the June 19, 2003 Division Decision. A March 24, 2005 trial resulted in the June 14, 2005 Final Judgment.

18. The District Court's June 14, 2005 Final Judgment found that the compensable injury does not extend to the MRI finding taken on April 16, 2002 (moderate desiccation of the L4-5 and L5-S1 discs with moderate loss in height in L5-S1 and central posterior bulge at the L5-S1 level becoming of protrusion severity along the right lateral margin) and /or lumbar herniations.

19. Services provided to Claimant for lumbar spine disc herniations are not reimbursable.

20. Provider failed to prove that total audited charges under § 134.401(c)(6)(A)(v) related to the compensable injury exceed $40,000.00.

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. Carrier 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 according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

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

5. There has been a final adjudication that the condition for which Claimant received services from Provider is a condition unrelated to the compensable injury.

6. Even though the service was preauthorized, Carrier is not liable to Provider when there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury. 28 TAC § 134.600(c), now 28 TAC § 134.600(d).

7. Carrier is not liable to Provider for the services related to Claimant because there has been a final adjudication that the compensable injury does not extend to the MRI finding taken on April 16, 2002 (moderate desiccation of the L4-5 and L5-S1 discs with moderate loss in height in L5-S1 and central posterior bulge at the L5-S1 level becoming of protrusion severity along the right lateral margin) and /or lumbar herniations.

8. 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.

9. 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.

10. 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.

11. Because Provider failed to prove the total audited charges under § 134.401(c)(6)(A)(v) related to the compensable injury exceed $40,000.00, the Stop-Loss Methodology does not apply to this case.

12. Provider is not entitled to additional reimbursement under the per diem methodology since Provider failed to show that the services for which it seeks additional reimbursement relate to a compensable injury.

13. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $36,727.97.

14. Based on the foregoing findings of fact and conclusions of law, Carrier does not owe Provider any additional reimbursement.

ORDER

It is hereby **ORDERED** that Vista Medical Center Hospital's request for additional reimbursement from Travelers Indemnity Company, for services provided to Claimant is **DENIED**. All other relief not expressly granted herein is **DENIED**.

SIGNED February 19, 2008.

HOWARD S. SEITZMAN
TOMMY L. BROYLES
ADMINISTRATIVE LAW JUDGES
STATE OFFICE OF ADMINISTRATIVE HEARINGS