SOAH DOCKET NO. 453-05-5864.M4
TWCC MDR NO. M4-04-1161-01

VISTA MEDICAL CENTER HOSPITAL, Petitioner	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
AMERICAN PROTECTION INSURANCE 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] denying additional reimbursement to Provider 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 (1997ACIHFG).[2] The Administrative Law Judge (ALJ) finds the Stop-Loss Exception should be followed in this proceeding. American Protection Insurance Company (Carrier) is ordered to pay additional reimbursement in the amount of $14,428.78, plus any applicable interest.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on March 23, 2005. Petitioner filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the parties, and the hearing convened on October 25, 2007. The record was left open at the parties request until November 14,

[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.

2007, for the possibility of settlement. The ALJ has received no notice of settlement. The record closed on November 14, 2007. This case was joined with other Stop-Loss cases for reasons of efficiency.[3]

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 $62,292.89 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. To date, Carrier has paid $32,097.84.

B. Issues

1. Summary of Positions and ALJ's Decision

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

	MRD	Provider	Carrier	ALJs
Charges	$62,292.89	$62,035.49[4]	$62,035.49	**$62,035.49**
Reimbursement Methodology	per diem[5]	x 75%	Stop Loss[6]	**x 75%**

[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] At the hearing, Provider agreed that its total charges should be reduced by $191.65 for duplicate charges and $65.75 for personal items.

Reimbursement Amount	$4,472.00	$46,526.62	$32,097.84	**$46,526.62**
Less Payment	($32,097.84)	($32,097.84)	($32,097.84)	**($32,097.84)**
Balance Due Provider	$0.00	$14,428.78	$0.00	**$14,428.78**

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."[7] The following legal issues in this case were decided by a SOAH En Banc Panel[8] (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.

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[5] MRD determined that the Stop-Loss Exception did not apply on the basis of its finding that the services were not unusually extensive. It applied the per-diem methodology for a two-day hospital stay at $1,118.00 per day for a reimbursement of $2,236.00. It also found Provider is entitled to additional reimbursement for implantables, but said cost invoices to support this charge were not submitted. It determined that no additional reimbursement was required based on Carrier's payment of $32,097.84.

[6] Carrier applied the Stop-Loss Exception to reviewed charges of $42,797.12 to arrive at a total reimbursement of $32,097.84 ($42,797.12 times 75 percent) after deducting $19,003.14 from Provider's total charges (in addition to the above-described charges for personal items and duplicate charges). Ex. 1 at 12. The $19,003.14 deduction was based on an "N" code notation, where Carrier stated additional documentation was needed to establish medical necessity. Ex. 1 at 12. However, Carrier did not identify the services referred to. Provider stated it forwarded all required documents to Carrier and that Carrier did not indicate which additional documentation was required. Ex. 1 at 17.

The ALJ concludes that Carrier's reasons for denial under the N code may not be considered. First, the ALJ is unable to determine whether the deductions were appropriate because the services to which the N code was applied were not identified. Second, the Division's rules at 28 TAC § 133.307(j)(2) provide that any denial reasons or defenses not raised before a request for medical dispute resolution may not be considered. The Division's rules in effect at the time of Carrier's denial, at 28 TAC § 133.304(c), required a sufficient explanation in an EOB to allow a provider to understand the insurance carrier's reasons for denying a claim; a generic statement of a reason for denial without a sufficient explanation is inadequate. Reading these rules together, the ALJ concludes that Carrier's reasons for denial are legally inadequate and may not be considered. Third, the services were preauthorized. Ex. 1 at 29. Preauthorized services may not be denied on the basis of a lack of medical necessity. TEX. LAB. CODE ANN. § 413.014.

[7] 28 TAC § 134.401(c)(6).

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

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 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 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.

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 reimbursement 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 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.[9]

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.[10] 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.

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

[9] 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.

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

III. FINDINGS OF FACT

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

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

3. Provider submitted itemized billing totaling $62,292.89 for the services provided to Claimant for the treatment in issue.

4. Provider's bill included charges in the amount of $16,190.00 for surgical implantables used to treat Claimant.

5. The $62,292.89 billed was Provider's usual and customary charges for these items and treatments.

6. Carrier has issued payments of $32,097.84 to Provider for the services in question.

7. Carrier denied further reimbursement to Provider.

8. Provider requested Dispute Resolution Services from the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) on charges totaling $62,292.89.

9. 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.

10. Based on its finding that the Stop-Loss Exception did not apply because Provider's services were not unusually extensive and that Carrier had paid $32,097.84, but owed $2,236.00, MRD found that Carrier owed no additional reimbursement.

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

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

13. On October 25, 2007, Administrative Law Judge James W. Norman 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 on November 14, 2007.

14. Provider waived $191.65 in duplicate charges and $65.75 for personal items to arrive at total charges of $62,035.49.

15. Provider deducted $19,003.14 from Provider's charges, based on its assertion that additional documentation was needed to establish medical necessity.

16. Carrier did not identify the services referred to in Finding of Fact No. 14.

17. Claimant's hospitalization was preauthorized.

18. Provider's audited charges under § 134.401(c)(6)(A)(v) are $62,035.49, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

19. Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $46,526.62. After deduction of Carrier's prior payment of $32,097.84, Provider is entitled to additional reimbursement of $14,428.78 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. Petitioner 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 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.

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. In denying a claim, an insurance carrier must provide a sufficient explanation in its explanation of benefits to allow a provider to understand its reasons for denying a claim; a generic statement of a reason for denial without a sufficient explanation is inadequate. 28 TAC § 133.304(c) (in effect at the time of the dispute.)

13. Carrier did not adequately comply with 28 TAC §§ 133.304(c) and 133.307(j)(2).

14. If a specified health care treatment or service is preauthorized, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service. TEX. LAB. CODE ANN. § 413.014.

15. It was impermissible for Carrier to deny preauthorized services based on a lack of medical necessity.

16. 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.

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

18. 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.

19. 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.

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

21. Applying the Stop-Loss Methodology in this case, Provider is entitled to total reimbursement of $46,526.62.

22. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $32,097.84 of this amount.

23. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $14,428.78, plus any applicable interest.

ORDER

It is hereby **ORDERED** that American Protection Insurance Company reimburse Vista Medical Center Hospital the additional sum of $14,428.78, plus any applicable interest, for services provided to Claimant.

SIGNED January 10, 2008.

JAMES W. NORMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS