SOAH DOCKET NO. 453-05-6409.M4
TWCC MDR NO. M4-04-9281-01

VISTA MEDICAL CENTER HOSPITAL, Petitioner	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
NORTH AMERICAN SPECIALITY INSURANCE, 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. North American Specialty Insurance (Carrier) is ordered to pay additional reimbursement in the amount of $28,919.77, plus any applicable interest.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on April 6, 2005. Provider filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the parties, and the hearing convened and closed on February 14, 2008.

[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.

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 $77,472.39 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. To date, Carrier has paid $20,732.02.

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	ALJ
Charges	$77,472.39	$77,472.39	$77,472.39	**$77,472.39**

[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] The MRD said the Stop-Loss Exception did not apply because the services were not unusually extensive. It applied the per-diem methodology for a six-day hospital stay at $1,118.00 per day for a total of $6,708.00 and paid implantables at cost plus 10 percent for a total of $707.14. It calculated total reimbursement at $7,415.14. Based on Carrier's $20,732.02 payment, it determined that Provider was not entitled to additional reimbursement.

[5] Provider said it should be paid according to the Stop-Loss Methodology. In relation to services that Carrier denied for lack of documentation, it said Carrier's failure to identify the services denied violated Division rules requiring an understandable reason for denying a claimBit also contended that Carrier failed to follow Division rules requiring insurers to request additional documentation within 14 days of receiving a bill. In relation to Carrier's denial of certain claims as medically unnecessary, it argued that preauthorized services may not be denied on that basis.

	MRD	Provider	Carrier	ALJ
Post Audit Charges	$7,415.14[4]	$77,472.39[5]	$20,732.02[6]	**$66,202.39**[7]
Methodology	per diem	x 75%	Unclear	**x 75%**
Reimbursement Amount	$7,415.14	$58,104.29	$20,732.02	**$49,651.79**
Less Payment	($20,732.02)	($20,732.02)	($20,732.02)	**($20,732.02)**
Balance Due Provider	$0.00	$37,372.27	$0.00	**$28,919.77**

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

[6] Carrier paid $20,732.02 after deducting $57,455.37 from Provider's $77,472.39 bill. It used denial code "F" to deduct $29,830.00, pending receipt of an invoice for implantables; reduced the bill by $6,910.67, using an "M" code, to fair and reasonable reimbursement; denied a $715.00 charge for duplicate billing; denied $11,270.00 for lack of documentation; and denied $8,729.70 for unnecessary treatment. It contended that its lack-of-documentation explanation was adequate based on notations on Provider's Table of Disputed Services in its medical-dispute-resolution request that Provider received an explanation of the undocumented services within 14 days of Carrier's receipt of the bill. It also asserted that it is permitted to deny as medically unnecessary certain services provided in conjunction with a preauthorized procedure, although it may not deny the admission itself and the specific procedure preauthorized.

[7] The ALJ concludes the Stop-Loss Methodology applies. He was unpersuaded by most of Carrier's reasons for denial. First, Carrier's use of an "F" code to indicate a need for an invoice for implantables is irrelevant to the Stop-Loss Methodology, which requires payment of 75 percent of audited charges, rather than cost plus 10 percent. Second, Carrier's denial on the basis of medically unnecessary services was inconsistent with Division rules in effect at the time of the denial at 28 TAC § 133.304(c), requiring a sufficient explanation in an EOB to allow a provider to understand the insurer's reasons for denying a claim and at 28 TAC § 133.307(j)(2), which says any denial reasons not raised before a medical-dispute-resolution request may not be considered. Carrier did not indicate which services it denied as medically unnecessary. The same is true for the denial for duplicate billing (involving a $715.00 charge)Bthe ALJ found six $715.00 charges in Provider's billing, described as room and board charges. In view of the fact that the hospital stay was for six days, it appears the billing was correct. And finally, Carrier is not permitted to deny individual items to fair and reasonable reimbursement when the Stop-Loss Methodology applies. See En Banc Panel Order at 9-10.

In relation to Carrier's denial of $11,270.00 in undocumented charges, the ALJ concludes that Provider was adequately informed of the undocumented itemsBProvider acknowledged on its Table of Disputed Services that it received an explanation of missing documentation within 14 days of Carrier's receipt of Provider's bill. Provider had the burden of proof, but failed to prove these items were adequately documented. Provider's audited charges should therefore be reduced by $11,270.00 to $66,202.39. Applying the Stop-Loss Methodology to that amount results in total reimbursement of $49,651.79. Deducting the $20,732.02 already paid, leaves the amount Carrier owes as $28,919.77.

costly services rendered during treatment to an injured worker."[8] The following legal issues in this case were decided by a SOAH En Banc Panel[9] (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).

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.[10]

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

[8] 28 TAC § 134.401(c)(6).

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

[10] 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.

customary charges and not to charges that are an average or median of other hospitals' charges.[11] Provider charged its usual and customary charges for the particular item or service.

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 her employment; her employer had coverage with North American Specialty Insurance (Carrier).

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

3. Provider submitted itemized billing totaling $77,472.39 for the services provided to Claimant for the treatment in issue.

4. The $77,472.39 billed was Provider's usual and customary charge for these items and treatments.

5. Carrier has issued payments of $20,732.02 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) on charges totaling $77,472.39.

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. Based on its finding that the Stop-Loss Exception did not apply because Provider's services were not unusually extensive and that Carrier has paid $20,732.02, but owes only $7,415.14, the MRD found that Carrier owed no additional reimbursement.

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.

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

12. On February 14, 2008, 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 February 14, 2008.

13. Carrier paid $20,732.02 after deducting $57,455.37 from Provider's $77,432.39 bill.

14. Carrier used denial code "F" to deduct $29,830.00, pending receipt of an invoice; reduced the bill by $6,910.67, using an AM@ code, to fair and reasonable reimbursement; denied a $715.00 charge for duplicate billing; denied $11,270.00, using an "N" code, for lack of documentation; and denied $8,729.70, using a "U" code, for unnecessary treatment.

15. There was insufficient evidence of Carrier's reason for denying charges on the basis of a lack of medical necessity and duplicate billing to allow Provider to understand Carrier's reasons for denial.

16. Carrier received an understandable explanation, within 14 days of Carrier's receipt of its bill, of Carrier's reasons for denying its claim for inadequate documentation.

17. There was insufficient evidence to find that Provider provided documentation in relation to certain items charged at $11,270.00.

18. Provider's audited charges under § 134.401(c)(6)(A)(v) are $68,742.69, 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 $49,651.79. After deduction of Carrier's prior payment of $20,732.02, Provider is entitled to additional reimbursement of $28,919.77 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 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 such as not sufficiently documented without a sufficient explanation of the insurance carrier's reasons is inadequate. 28 TAC § 133.304(c).

13. Carrier did not adequately comply with 28 TAC §§ 133.304(c) and 133.307(j)(2) (in effect at the time of the dispute) in denying Provider's claim on the basis of a lack of medical necessity and duplicate billing.

14. The need for a invoice cost for implantables was irrelevant because the Stop-Loss Methodology applies.

15. When the Stop-Loss Methodology applies, the cost of individual items is not reduced to a fair and reasonable amount.

16. Carrier's total audited charges should be reduced by $11,270.00, from $77,472.99 to $66,202.39.

17. 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.

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

19. 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.

20. 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.

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

22. Applying the Stop-Loss Methodology in this case, Provider is entitled to total reimbursement of $49,651.79.

23. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $20,732.02 of this amount.

24. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $28,919.77, plus any applicable interest.

ORDER

It is hereby **ORDERED** that North American Specialty Insurance reimburse Vista Medical Center Hospital the additional sum of $28,919.77, plus any applicable interest.

SIGNED March 21, 2008.

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