SOAH DOCKET NO. 453-05-6445.M4
TWCC MDR NO. M4-04-6382-01

VISTA MEDICAL CENTER HOSPITAL,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
TRAVELERS INDEMNITY COMPANY	§	
OF CONNECTICUT,	§	
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. Travelers Indemnity Company of Connecticut (Carrier) is ordered to pay additional reimbursement in the amount of $84,577.64, plus any applicable interest.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on March 30, 2005. Provider filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the parties, and the hearing

[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.

convened and closed on February 14, 2008. 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 $230,551.36 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. To date, Carrier has paid $88,335.88.

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	$230,551.36	$230,551.36	$230,551.36	**$230,551.36**
Reimbursement Methodology	per diem[4]	x 75%	Unknown[5]	**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] 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 ten-day hospital stay for a reimbursement of $11,180.00. It found that Provider is entitled to additional reimbursement for implantables at cost plus 10 percent for a total of $36,041.50. Based on Carrier's $88,355.88 payment, it determined that Provider was not entitled to additional reimbursement.

[5] Carrier described its payment as "SMAX," meaning "state maximum," for 11 of the 16 revenue codes billed; "DOP," meaning fair and reasonable reimbursement for 3 revenue codes; and "NDOC," meaning not enough detailed information to determine the appropriateness of the billed procedure for 2 revenue codes. Carrier's Ex. 14 at 2. Carrier

	MRD	Provider	Carrier	ALJ
Reimbursement Amount	$47,221.50	$172,913.52	$88,335.88	**$172,913.52**[6]
Less Payment	($88,335.88)	($88,335.88)	($88,335.88)	**($88,335.88)**
Balance Due Provider	$0.00	$84,577.64	$0.00	**$84,577.64**

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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argued it is well-known that DOP stands for documentation of procedure. (Its notation describes DOP as reimbursed per the insurance carrier's fair and reasonable allowance.) It addressed DOP in relation to an OR Minor procedure, for which it paid $250.00 of a $9,200.00 charge. It contended that the OR Minor procedure is not documented in Provider's records. It cited NDOC in relation to a pharmacy charge, for which it paid $5,810.16 of an $8,514.67 charge, and in relation to a medical-surgical-supply charge, for which it paid $10,667.24 of a $24,628.40 charge.

[6] The ALJ was not persuaded by Carrier's reasons for denial. The SMAX reason for denial was inconsistent with the Stop-Loss Methodology, which requires payment of 75 percent of total audited charges.

Carrier's use of the NDOC reason for denial was inconsistent with the Division's rules in effect at the time of the denial at 28 TAC § 133.304(c), which requires a sufficient explanation in an EOB to allow a provider to understand the insurance carrier's reasons for denying a claim, rather than a generic statement that simply states a conclusion such as not sufficiently documented, and at 28 TAC § 133.307(j)(2), which provides that any denial reasons or defenses not raised before a request for medical dispute resolution may not be considered. Carrier indicated that some, but not all, of the pharmacy and medical-surgical supply charges contained insufficient information to determine the appropriateness of the billed charge. However, it did not identify which charges were improperly documented. There were over 300 billed charges for medical-surgical supplies and approximately 170 billed pharmacy charges. Some charges were documented in Provider's medical records. See Provider's Ex. 1 at 30-53. The ALJ concludes that Carrier's explanation of its reasons for denying these charges was not sufficiently understandable. Reading these Rules 133.304(c) and 133.307(j)(2) together, the ALJ concludes that Carrier's reasons for denial are inadequate and may not be considered. This reading is consistent with Rule 133.301(d), in effect at the time of the dispute, which requires an insurer to clearly indicate specific documentation and its specific reasons when it requests additional documentation.

Carrier's use of the "DOP"reason for denial based on a fair and reasonable allowance was inconsistent with the Stop-Loss Methodology. When the Stop-Loss Methodology is used, as in this case where audited charges exceed $40,000.00, it is impermissible to audit individual charges for fair and reasonable reimbursement. See En Banc Panel decision at 9-10. Carrier argued it is well-known that the DOP code means "documentation of procedure." However, Carrier's explanation stated the charge was reduced to fair and reasonable reimbursement.

[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

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 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 Travelers Indemnity Company of Connecticut (Carrier).

(Lead Docket), issued January 12, 2007.

[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.

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

3. Provider submitted itemized billing totaling $230,551.36 for the services provided to Claimant for the treatment in issue.

4. The $230,551.36 billed was Provider's usual and customary charge for these items and treatments.

5. Carrier has issued payments of $88,335.88 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 $230,551.36.

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 $88,335.88, but owes less than that amount, 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.

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, 2007.

13. Carrier denied charges on three bases, with a "SMAX" notation indicating that the charge exceeded the state maximum; with a "DOP" notation indicating that some charges were reduced to a fair and reasonable allowance; and with a "NDOC" notation indicating that the documentation did not provide enough detailed information to determine the appropriateness of the billed service or procedure for revenue codes 250 for pharmacy and 270 for medical-surgical supplies.

14. There were approximately 170 separate pharmacy charges and over 300 medical-surgical supply charges.

15. Carrier paid for some but not all of the pharmacy and medical-surgical-supply bills.

16. Carrier did not specify which of the pharmacy and medical-surgical-supply charges it was paying and which it was not.

17. Carrier did not provide a sufficient explanation to allow Provider to understand Carrier's reasons for denying the pharmacy and surgical-supply services.

18. Provider's audited charges under § 134.401(c)(6)(A)(v) are $230,551.36, 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 $172,913.52. After deduction of Carrier's prior payment of $88,335.88, Provider is entitled to additional reimbursement of $84,577.64 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. When the Stop-Loss Methodology applies, items are not audited to a fair and reasonable amount.

10. When the Stop-Loss Methodology applies, there is no state maximum limit other than as stated in the Stop-Loss Methodology.

11 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.

12 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).

13. 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.

14. 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).

15. 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 for pharmacy and medical-surgical-supply charges.

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 $172,913.52.

22. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $88,335.88 of this amount.

23. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $84,577.64, plus any applicable interest.

ORDER

It is hereby **ORDERED** that Travelers Indemnity Company of Connecticut reimburse Vista Medical Center Hospital the additional sum of $84,577.64, plus any applicable interest, for services provided to Claimant.

SIGNED March 17, 2008.

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