SOAH DOCKET NO. 453-06-0037.M4
TWCC MDR NO. M4-05-8979-01

VISTA HOSPITAL OF DALLAS,	**§**	**BEFORE THE STATE OFFICE**
Petitioner	**§**	
V.	**§**	**OF**
AMERICAN HOME ASSURANCE	**§**	
COMPANY,	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Vista Hospital of Dallas (Vista) requested a hearing to contest a decision by the Medical Review Division (MRD) of the Texas Department of Insurance, Division of Workers' Compensation (Division), denying additional reimbursement to Vista for surgery and a hospital stay provided to Claimant, an injured worker.1 American Home Assurance Company (Carrier) had paid Vista $24,190.60. Vista sought an additional $88,643.11. Carrier denied payment based on its assertions that Vista inappropriately calculated its charges on the basis of the ACIHFG Stop-Loss Exception;[2] some of the services were not medically necessary; some of the services were not appropriately documented; and some of the services were improperly "unbundled," rather than being included with other services as part of a global charge (G Issue). The Administrative Law Judges (ALJs) find that the Stop-Loss Methodology should be followed in this proceeding and that additional reimbursement in the amount of $88,643.11, plus applicable interest, should be ordered.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

The MRD issued its decision on August 23, 2005. Vista filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the parties, and the hearing convened

[1] In its August 23, 2005 order, MRD concluded that the Stop-Loss Exceptions of the Division's 1997 Acute Care Inpatient Hospital Fee Guideline (ACIHFG), 28 TEX. ADMIN. CODE (TAC) § 134.401, did not apply to this case because Vista's services were not unusually costly as contemplated by the ACIHFG.

[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 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.

and concluded on May 23, 2007. Prior to issuance of a decision, the case was joined with other stop-loss cases for reasons of efficiency.[3]

II. DISCUSSION

A. Background

It is undisputed that Claimant was admitted to Vista on July 2, 2004, for spine surgery because of a central herniated disk at his L5-S1 spinal level, with marked disk degeneration and disk space collapse at L5-S1. He underwent a 360 degree spinal fusion at L5-S1 with implants. He was discharged on July 6, 2004.

On May 27, 2004, Carrier preauthorized a two-day hospital stay between May 27, 2004, and June 30, 2004.4 Subsequently, it authorized an additional two-day stay.5

Vista billed Carrier $151,172.80 of which Carrier paid $24,190.60. There was no applicable maximum allowable reimbursement (MAR) schedule or specific services contract. Vista waived its $727.85 G Issue reimbursement request.

B. Issues

1. Summary of Positions and ALJs' Decision

The ALJs will order reimbursement in accordance with the following calculation:

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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] Ex. 1 at 69-70.

[5] Ex. 1 at 71-72.

Amount billed	$151,172.80
Less G Issue-related charges	727.85
Remaining Charges	150,444.95
Stop loss amount (75% x 150,444.95)	112,833.71
Less amount paid by Carrier	24,190.60
Amount owed to Vista (net of interest)	$88,643.11

2. En Banc Panel Decision

When a hospital's total audited bill is greater than $40,000, the ACIHFG 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."[6] The following legal issues in this case were decided by a SOAH En Banc Panel[7] (En Banc Panel), and those determinations are incorporated herein. The ALJs agree with those determinations. Legal arguments related to these issues will not be addressed, other than in the Conclusions of Law.

- 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 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.

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

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

- 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).

- The ALJs find that a hospital is not required to establish eligibility for applying the Stop-Loss Reimbursement Methodology under § 134.401(c)(4) by showing that the services were unusually costly or unusually extensive in addition to showing that total audited charges exceed $40,000.

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 refer to the provider's own usual and customary charges, rather than to charges that are an average or median of other hospitals' charges.[8] Thus, Vista is required to charge its usual and customary charges.

3. Explanation of Benefits (EOB)

In accordance with the En Banc Panel's decision, reasons for denying a claim that were not provided to a provider before a request for medical dispute resolution may not be considered. As indicated above, in its EOB, Carrier challenged Vista's charges on three bases, in addition to the G Issue charges for which Vista is not pursing reimbursement.

Carrier's first reason for denial is that the charge should be reduced because the ACIHFG Stop-Loss Exception does not apply to this case. This is contrary to the En Banc Panel's ruling that the exception applies when total audited charges exceed $40,000, based on the provider's usual and customary charges. In this case, total audited charges exceeded $40,000 and testimony from Vista witness Rita Morales established that the services Vista billed9 were for the same charge as its usual and customary charge for each patient regardless of the service or payer. On these bases, the Stop-Loss Exception applies and Vista's reimbursement should be determined in accordance with its terms.

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

[9] Ex. 1 at 4-14.

A second ground for denial stated in Carrier's EOB was that some services were medically unnecessary. Carrier argued that once an insurance carrier raises the issue of medically unnecessary services as a reason for denial in its EOB, a provider has the burden of proving that the services were medically necessary. The ALJs conclude that Carrier is barred from raising the medical necessity issue. As indicated above, Carrier preauthorized Claimant's hospitalization and surgery for a 360 degree spinal fusion with inpatient stay of two days and then preauthorized an additional two days.[10] The Division's rules at 28 TAC § 133.301(a) (effective at the time of this dispute) provide that when a service is preauthorized, an insurance carrier is not permitted to retrospectively review the medical necessity of the service.

Carrier contended that some of the services provided were medically unnecessary even though the surgery and length of stay were preauthorized and that some of the services were not included in the preauthorization. As previously discussed, however, Rule 133.307(j)(2) states that a reason for denial not presented to the provider before a request for medical dispute resolution may not be considered. All of the insurers participating in the proceeding that led to the En Banc Panel's decision recognized that subsection (j)(2) limits the reasons for denying a claim that an insurance carrier may assert at medical dispute resolution or at hearing. To the extent Carrier now contends that some of the services Vista provided were outside the ambit of its preauthorization, it is not permitted to do so under Rule 133.307(j)(2) because it did not assert that reason before Vista's request for medical dispute resolution.[11]

[10] Carrier pointed out that the initial preauthorization was for services to be performed between May 27, 2004, and June 30, 2004 (Ex. 1 at 69), but that the services were not performed until July 2, 2004. Ms. Morales agreed with questions from Carrier that the July 2 procedure was not preauthorized. Carrier did not argue this matter in closing. The ALJs are not persuaded by any assertion that the July 2-3 procedure was not preauthorized because Carrier did not include that reason in its EOB as a ground of denial. Under 28 TAC § 133.307(j)(2) (effective at the time of this dispute), a reason for denial not presented to the provider before a request for medical dispute resolution may not be considered. In addition, based on the fact that the Carrier extended the preauthorization for two additional days with full knowledge of the initial two-day stay and date of surgery, the ALJs conclude that Carrier waived any claim that the initial procedure and two-day stay were not preauthorized, *i.e.*, the additional two-day preauthorization is inconsistent with a position that the initial two-day stay was not authorized.

[11] Ex. 1 at 55-59.

In addition, on the basis of other related law, the ALJs conclude that Carrier's assertion of a lack of medical necessity, based on any assertion that its preauthorization did not apply, is impermissible. Labor Code § 408.027(e) (formerly 408.027(d)) provides:

> (e) If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the division, the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee. The insurance carrier is entitled to a hearing as provided by Section 413.031(d).

The Division's rules at 28 TAC § 133.304(c) (effective at the time of the dispute at issue) provide:

> (c) At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's actions. A generic statement that simply states a conclusion such as "non sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial does not satisfy the requirements of this section.

Subsections (c), (k), (l), and (m) of 28 TAC § 133.304 (effective at the time of this dispute at issue) provide a process whereby a provider and an insurance carrier inform each other of their reasons for submitting or denying a claim, including a requirement that providers request reconsideration of a denied claim before submitting a request for medical dispute resolution. The rules provide time limitations for the insurance carrier and provider to take action.[12] This process is obviously thwarted if the insurance carrier never provides an understandable reason for its decision. Because Carrier failed to follow Labor Code 408.027(e) and Rule 133.304(c) by informing Vista prior to medical dispute resolution of any assertion that not all the services at issue were preauthorized, it may not now assert that ground for denial.

[12] The evidence shows that Vista sent its bill to Carrier and that Carrier received it on September 21, 2004. Ex. 1 at 24-25. Vista witness Rita Morales testified that when Carrier did not respond, Vista resent the bill on October 18, 2004. Vista faxed a "Request for Reconsideration" on November 10, 2004. Ex. 1 at 4-15, 29.

Carrier's assertion of a lack of medical necessity was inadequate for a third related reason. Carrier witness Dana Retrum testified that she could not tell which of the over 350 specifically-identified Vista services[13] Carrier denied as not medically necessary. Although Ms. Retrum could see that Carrier denied certain dollar amounts under certain billing codes, she could not tell which of Vista's numerous charges under a particular billing code were denied. There was virtually no explanation of why the services were determined to be medically unnecessary.[14] Thus, even if Carrier's challenge to the medical necessity of some of the services were not barred for other reasons, Carrier's explanation was inadequate under applicable law[15] for this additional reason. As a result, it may not assert this ground for denial.

A third ground for denial, stated under an "N" denial code in Carrier's EOB, was that certain services were not properly documented. The ALJs conclude that Labor Code 408.027(e) and Rules 133.304(c) and 133.307(j)(2) prevent Carrier from asserting the N code issue. Both of Carrier's witnesses, Carol Galimore and Dana Retrum, and Vista witness Rita Morales testified they could not tell which of the Vista charges the N denial code referred to. Ms. Retrum agreed it was probably impossible for Vista to figure out which charges were denied on that basis.

Construing Labor Code § 408.027(e) and Rules 133.304(c) and 133.307(j)(2) together demonstrates that Carrier's N-code denial failed to satisfy the Rule 133.307(j)(2) provision that new or additional denial reasons not presented before a request for medical dispute resolution may not be subsequently considered. The above-described testimony showed that Carrier did not comply with the Labor Code § 408.027(e) or Rule 133.304(c) requirements that an understandable explanation of

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[13] Ex. 1 at 4-14.

[14] At one place under the UY (medically unnecessary) denial code, Carrier asserted that $20.45 worth of convenience items, under billing code 270, were not allowed under the guidelines, but again, it did not identify which of the numerous billing code 270 charges it was referring to. There was no specific $20.45 billing code 270 charge in Vista's bills. Ex. 1 at 4-14.

A frequent reason for Carrier's denial of charges on the basis of medical necessity was the non-medical necessity rationale of "overcharge and/or excessive amount for services rendered." Ex. 1 at 56-58. Rather than being a medical necessity issue, this assertion appears to be subsumed within the issue of whether to apply the Stop-Loss Exception.

[15] Labor Code 408.027(e); Rules 133.304(c) and 133.307(j)(2).

the reasons or reasons for the insurance carrier's actions be provided. Labor Code § 408.027(e) and Rules 133.304(c) and 133.307(j)(2) should be read together to achieve a consistent result, *i.e.*, the reason for denial required by Rule 133.302(j)(2) must be understandable.16

Carrier's N-code denial should also be barred for the separate but related reason that the denial failed to comply with the requirements of Labor Code § 408.027 and Rule 133.304(c).17

III. FINDINGS OF FACT

1. Claimant sustained a compensable injury in the course and scope of his employment.

2. Claimant's employer had workers' compensation insurance coverage with American Home Insurance Company (Carrier).

3. Claimant was admitted to Vista Hospital of Dallas (Vista) on July 2, 2004, for spine surgery because of a central herniated disk at his L5-S1 spinal level and marked disk degeneration and disk space collapse at L5-S1.

4. Claimant underwent a 360 degree spinal fusion at L5-S1 with implants.

5. Claimant was discharged on July 6, 2004.

6. On May 27, 2004, Carrier preauthorized a two-day hospital stay between May 27, 2004, and June 30, 2004.

7. Carrier subsequently authorized an additional two-day stay.

8. Vista billed Carrier $151,172.80 for the preauthorized services of which Carrier paid $24,190.60.

9. Vista requested medical dispute resolution.

10. On August 23, 2005, the Texas Workers' Compensation Commission Medical Review Division (MRD) issued its Findings and Decision, holding that no further reimbursement was owed by Carrier.

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[16] Construing Rule 133.302(j)(2) to require that grounds for denying a claim that were not stated before medical dispute resolution may not be considered, but not requiring the grounds to be stated in an understandable fashion would lead to contradictory results between the practical functioning of the rule and its intended effect.

[17] As a separate consideration, 28 TAC § 133.301(d)(1) and (5) provides that when an insurance carrier requests additional documentation, it must indicate the specific documentation it is requesting and make the request not later than the 14th day after the receipt of a medical bill. Carrier did not do so in this case.

11. Vista requested a hearing not more than 20 days after receiving the MRD decision.

12. All parties received not less than 10 days' notice of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

13. All parties had an opportunity to respond and present evidence and argument on each issue involved in the case.

14. Vista waived its reimbursement request of $727.85 relating to Carrier's denial of certain services based on its assertion that the services were improperly unbundled rather than being included in a global charge with other charges.

15. Other reasons Carrier asserted as grounds for denying the charges were that the 1997 Acute Care Inpatient Hospital Fee Guideline (ACIHFG) Stop-Loss Exception did not apply to Vista's charge; some of the services were medically unnecessary; and some of the services were not properly documented.

16. Vista's total audited charges were in excess of $40,000.

17. Vista billed its usual and customary charges.

18. There was no applicable maximum allowable reimbursement (MAR) schedule or specific services contract.

19. Carrier failed to state as a reason for denying any of the claims prior to medical dispute resolution that the services at issue were not included within the scope of its preauthorization.

20. Vista failed to state as a reason for denying any of the claims prior to medical dispute resolution that its preauthorization did not apply to the July 2, 2004 surgery and hospital admission.

21. Carrier did not identify which of the over 350 specific Vista charges it asserted were medically unnecessary.

22. Carrier did not identify which of the over 350 specific Vista charges it asserted were not properly documented.

23. Vista's billed amount of $151,172.80, less $727.85, multiplied times 75 percent equals $112,833.71.

24. $112,833.71 less $24,190.60 equals $88,643.11.

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

5. All eligible items, including the items listed in 28 TAC § 134.401(c)(4), are included in the calculation of the $40,000 Stop-Loss Threshold. 28 TAC § 134.401.

6. In determining 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 MAR or a specific contract. 28 TAC § 134.401.

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. 28 TAC § 134.401.

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. 28 TAC § 134.401.

9. Under the Stop-Loss Reimbursement 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 Reimbursement Methodology applies. 28 TAC § 134.401.

10. 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). 28 TAC § 134.401.

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. 28 TAC § 133.307 (effective at the time of the dispute at issue.)

12. There is no additional requirement for a hospital to separately establish that any or all of the services were unusually costly or unusually extensive in order to for a provider to establish eligibility to apply the Stop-Loss Reimbursement Methodology. 28 TAC § 134.401.

13. The Stop-Loss Reimbursement Methodology applies in this case.

14. Carrier's assertion that some of the services were not medically necessary should not be considered at the hearing. TEX. LAB. CODE ANN. § 408.027(e); 133.304(c) (effective at the time of this dispute); and 28 TAC § 133.307(j)(2) (effective at the time of this dispute).

15. Carrier's assertion that some of the services were not properly documented should not be considered at the hearing. TEX. LAB. CODE ANN. § 408.027(e); 28 TAC §§ 133.301(a) (effective at the time of this dispute); 133.304(c) (effective at the time of this dispute); and 28 TAC § 133.307(j)(2) (effective at the time of this dispute).

16. Carrier should pay Vista $88,643.11, plus any applicable interest.

ORDER

It is hereby **ORDERED** that American Home Insurance Company reimburse the Vista Hospital of Dallas the additional sum of $88,643.11, plus any applicable interest, for services provided to Claimant.

SIGNED 27, 2007.

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