SOAH DOCKET NO. 453-04-5186.M5

ZENITH INSURANCE COMPANY,	**§**	**BEFORE THE STATE OFFICE**
Petitioner and Cross-Respondent	**§**	
	§	
V.	**§**	**OF**
	§	
VISTA MEDICAL CENTER HOSPITAL,	**§**	
Respondent and Cross-Petitioner	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Zenith Insurance Company (Carrier) requested a hearing on a decision by the Medical Review Division (MRD) of the Texas Department of Insurance, Division of Workers' Compensation (Division),[1] ordering additional reimbursement to Provider for a hospital stay provided to Claimant, an injured worker. Carrier argued that reimbursement for this admission should not 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] Carrier also argued that certain of the preauthorized procedures were not medically necessary based upon a retrospective peer review. Vista Medical Center Hospital (Provider) also requested a hearing. Provider disputed a decision by MRD denying reimbursement to Provider based upon MRD's determination that the request for medical dispute resolution was not timely filed.

The Administrative Law Judges (ALJs) find the Stop-Loss Exception should be followed in this proceeding. Issues decided as preliminary matters by Order dated June 20, 2005, were that Provider timely filed a request for medical dispute resolution and that while Carrier may audit, it may not challenge the medical necessity of individual items, treatments or services when the inpatient surgical procedure was preauthorized.

Accordingly, Carrier is ordered to pay additional reimbursement in the amount of

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[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 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.

$66,995.65, plus any applicable interest.[3]

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on March 4, 2004. Both Provider and Carrier filed timely and sufficient requests for hearing. A prehearing conference was properly noticed and convened on January 11, 2005, to consider certain preliminary issues.[4] Notice of the hearing on the merits was appropriately issued to the parties. The hearing on the merits convened and concluded on July 31, 2007.[5]

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 $119,237.40 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. The bill included $49,419.00 for surgical implantables. To date, Carrier has paid $22,432.40.

B. Issues

1. Summary of Positions and ALJs' Decision

Applying the rulings in the June 25, 2007 Order regarding the medical necessity challenge to the facts in evidence, the ALJs conclude the Carrier may not challenge medical necessity, failed to prove the preauthorization was obtained by fraud or deceit, and failed to audit.

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[3] The preliminary hearing was convened by ALJ Howard S.Seitzman. The hearing on the merits was convened by ALJ James W. Norman. Both ALJs have reviewed and concur in this Decision and Order.

[4] A briefing period followed the January 11, 2005 hearing, and the preliminary issues were decided by Order dated June 20, 2005.

[5] 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.

As to the medical necessity challenge, having preauthorized the inpatient surgical procedure, Carrier may not challenge the medical necessity of individual items, treatments or services under either a "U" or a "V" denial code and receive an Independent Review Organization (IRO) review of medical necessity.[6]

Carrier may present evidence that preauthorization was obtained by fraud or deceit. The evidence presented in the Forté letter, characterized by Carrier as a "peer review," does not prove fraud or deceit in obtaining the two-day inpatient extension.[7] While Joel D. Wilk, M.D., states in the Forté letter that a two-day extension would not have been authorized had a "true picture" of Claimant's status been submitted with the request, the statements upon which Dr. Wilk's conclusion is based are ambivalent and acknowledge that certain data he reviewed may be incomplete.[8] Additionally, it should be noted that the Forté letter is not a sworn document and that Dr. Wilk did not testify. Dr. Wilk's area of specialty, if any, is not identified. Nevertheless, he opines in the areas of anesthesia, orthopedic surgery, radiology, pharmacology, and computer programing. Dr. Wilk also relied in part upon the opinions of an unidentified individual. Accordingly, the ALJs give little, if any, weight to Dr. Wilk's unsworn statements and his conclusions. Carrier failed to sustain its burden of proof on this issue.

Carrier, having preauthorized the inpatient surgical procedure, may audit and dispute specific charges associated with individual items, treatments or services provided by Provider. Although Dr. Wilk suggested a "full bill audit,"[9] Carrier did not conduct an audit. Even if one treats the Forté letter as an audit and not a medical necessity peer review letter, the statements presented in the Forté letter raise questions but fail to prove alleged unbundling of charges, duplicate charges, or other deficiencies associated with individual items, treatments or services provided by Provider. Again, the ALJs give little, if any, weight to Dr. Wilk's unsworn statements and his conclusions. Carrier failed to sustain its burden of proof on this issue.

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[6] 28 TEX. ADMIN. CODE (TAC) § 133.301(a) provides that when the healthcare provider has obtained preauthorization, the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment and/or services. Prospective medical necessity disputes reviewable by an IRO are defined at 28 TAC § 133.305(a)(3) and are limited to circumstances prior to the provision of the health care.

[7] Carrier's Ex. 2, pp. 32-35.

[8] Carrier's Ex. 2, pp. 32-33.

[9] Carrier's Ex. 2, pp. 34.

Finally, Provider timely filed its request for hearing. The dates of service in dispute are July 5, 2002, through July 10, 2002. On June 23, 2003, Provider filed its Medical Dispute Resolution Request (MDR Request) for the dates of service in dispute. MRD rejected Provider's MDR Request because Provider had not completed the IRO section of the MDR Request form. MRD required Provider to complete the IRO section of the MDR Request form and submit payment for an IRO review because the Carrier had challenged the medical necessity of certain services and items provided to Claimant. On July 7, 2003, MRD received Provider's MDR Request form with the IRO section completed and payment for an IRO review. Subsequently, MRD learned the procedure had been preauthorized, determined that an IRO review was not allowed under 28 TAC § 133.301(a), and returned the IRO review payment to Provider. Despite acknowledging its error in requiring Provider to complete the IRO section of the MDR Request form, MRD considered the July 7, 2003 MDR Request filing the operative filing and excluded the June 23, 2003 MDR Request filing. Using the later filing as the operative filing, MDR excluded the July 5 and 6, 2002 dates of service because the MDR Request was filed more than one year after the date of service.

Because the service was preauthorized, review of medical necessity by an IRO was precluded. The Commission erred in rejecting Provider's June 23, 2003 MDR Request. Provider's MDR Request was timely filed within one year from the provision of the service.

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

	MRD	**Provider**	**Carrier**	**ALJs**
Charges	$116,175.60	$119,237.40	$119,237.40	**$119,237.40**
75% Stop Loss Methodology	applied Stop-Loss Exception [10]	x 75%	applied standard per diem rate[11]	**x 75%**
Reimbursement Amount	$7,801.48	$89,428.05	$22,432.40	**$89,428.05**

[10] MRD calculated that Provider billed $116,175.60 for the inpatient hospitalization from July 5, 2002, through July 10, 2002. MRD then excluded the charges from July 5 and 6, 2002, leaving charges of $10,401.97 (room and board-3 days @ $715.00 per day = $2,145.00, pharmacy $3,061.80, and supplies $5,195.17).

[11] Carrier reimbursed a total of $22,432.40 ($3,354.00 for room and board and $19,078.40 for supplies and implants). The original preauthorization was for a three-day hospital stay. On July 9, 2002, an additional two days were authorized, for a total stay of five days. It appears to the ALJs that Carrier reimbursed three days at the $1,118.00 per diem reimbursement rate and did not reimburse the additional two days. Otherwise, Carrier would have reimbursed at $670.80 per day, an amount that does not coincide with any 1997 ACIHFG per diem rate.

Less Payment	($2,012.40)	($22,432.40)	($22,432.40)	**($22,432.40)**
Balance Due Provider	$5,789.08	$66,995.65	$0.00	**$66,995.65**

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."[12] The following legal issues in this case were decided by a SOAH En Banc Panel[13] (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 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.

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[12] 28 TAC § 134.401(c)(6).

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

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.[14] Provider is required to charge its usual and customary charges. The parties stipulated the charges assessed were Provider's usual and customary 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.

III. FINDINGS OF FACT

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

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

3. Provider submitted itemized billing totaling $119,237.40 for the services provided to Claimant for the treatment in issue.

4. Provider's bill included charges in the amount of $49,419.00 for surgical implantables used to treat Claimant.

5. The $119,237.40 billed was Provider's usual and customary charges for these items and treatments.

6. Carrier did not perform an on-site audit of the bill, but relied on a Forté peer review letter authored by Joel D. Wilk, M.D.

7. Because the statements and conclusions of Dr. Wilk are ambivalent and acknowledge that certain data he reviewed may be incomplete; the Forté peer review letter is not a sworn document; Dr. Wilk did not testify; Dr. Wilk opines in the areas of anesthesia, orthopedic surgery, radiology, pharmacology, and computer programing without identifying his area of specialty, if any; and Dr. Wilk relied in part upon the opinions of an unidentified individual; no weight is accorded to Dr. Wilk's unsworn statements and his conclusions.

8. Even if one treats the Forté letter as an audit and not a medical necessity peer review letter, the statements presented in the Forté letter raise questions but fail to prove unbundling of charges, duplicate charges, or other deficiencies associated with individual items, treatments or services provided by Provider.

9. Carrier reimbursed Provider according to the per diem methodology.

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

10. Carrier has issued payments of $22,432.40 to Provider for the services in question.

11. Carrier denied further reimbursement to Provider.

12. Both Carrier and Provider requested Dispute Resolution Services from the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission).

13. 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.

14. MRD issued its Findings and Decision, holding that further reimbursement was owed by Carrier.

15. Carrier timely filed a request for a contested case hearing on the MRD's decision.

16. On June 23, 2003, Provider timely filed a request for a contested case hearing on the MRD's decision.

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

18. A prehearing conference was properly noticed and convened on January 11, 2005, by Administrative Law Judge Howard S. Seitzman to consider certain preliminary issues.

19. A briefing period followed the January 11, 2005 hearing, and the preliminary issues were decided by Order dated June 20, 2005.

20. Issues decided as preliminary matters by Order dated June 20, 2005, were that Provider timely filed a request for medical dispute resolution and that while Carrier may audit, it may not challenge the medical necessity of individual items, treatments or services when the inpatient surgical procedure was preauthorized.

21. On July 31, 2007, Administrative Law Judge James W. Norman convened a hearing on the merits at the hearing facilities of the State Office of Administrative Hearings 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 July 31, 2007.

22. Provider's total audited charges under § 134.401(c)(6)(A)(v) are $119,237.40, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

23. Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $89,428.05. After deduction of Carrier's prior payment of $22,432.40, Provider is entitled to additional reimbursement of $66,995.65, plus any applicable interest, 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. Carrier timely requested a hearing, as specified in 28 TAC § 148.3.

4. Proper and timely notice of the hearing was provided to the parties according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Petitioner and Cross-Petitioner had the burden of proof in this proceeding pursuant 28 TAC § 148.21(h) and (i) on those issues for which they sought affirmative relief.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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).

12. 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.

13. A hospital, Provider in this case, establishes eligibility for applying the Stop-Loss Methodology under 28 TAC § 134.401(c)(4) 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.

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

15. 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.

16. 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.

17. The Staff Report has no legal effect for the cases subject to this order.

18. Having preauthorized the inpatient surgical procedure, Carrier may not challenge the medical necessity of individual items, treatments or services under either a "U" or a "V" denial code and receive an Independent Review Organization (IRO) review of medical necessity. 28 TAC § 133.301(a).

19. Carrier failed to prove the preauthorization was obtained by fraud or deceit.

20. Carrier failed prove unbundling of charges, duplicate charges, or other deficiencies associated with individual items, treatments or services provided by Provider.

21. Applying the Stop-Loss Methodology in this case, Provider is entitled to total reimbursement of $89,428.05.

22. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $22,432.40 of this amount.

23. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $66,995.65, plus any applicable interest.

ORDER

It is hereby **ORDERED** that Zenith Insurance Company reimburse Vista Regional Medical Center Hospital the additional sum of $66,995.65, plus any applicable interest, for services provided to Claimant.

SIGNED August 30, 2007.

JAMES W. NORMAN
HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGES
STATE OFFICE OF ADMINISTRATIVE HEARINGS