SOAH DOCKET NO. 453-04-8356.M4
TWCC NO. M4-03-1407-01

TEXAS MUTUAL INSURANCE CO.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
VISTA MEDICAL CENTER HOSPITAL,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

The Medical Review Division (MRD) of the Texas Workers'Compensation Commission[1] (Commission) granted Vista Medical Center Hospital's (Vista's) request for additional reimbursement of $120,301.55 for services it provided to a workers' compensation claimant during an inpatient hospital admission on November 6 through 22, 2001. MRD determined that TMIC improperly carved out the cost of implantables and used the *per diem* reimbursement method when Vista qualified for stop-loss reimbursement. The Administrative Law Judge (ALJ) finds that TMIC met its burden of proving the *per diem* method should be used for calculating Vista's reimbursement, and Vista is entitled to no additional reimbursement.

II. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

Attorneys Thomas B. Hudson, Jr., and Christopher H. Trickey represented TMIC, and attorney David F. Bragg represented Vista. The parties did not contest notice and jurisdiction.

This case was consolidated with Docket No. 453-03-2412.M4 for the purpose of resolving preliminary legal issues, and the order addressing those issues, Order No. 14 in Docket No. 453-04-2412.M4, was issued on November 22, 2005. Upon the parties' request, this case was abated from February 21, 2006, to April 4, 2007, when it was reinstated on the docket. Rather than having a contested case hearing, the parties elected to file written stipulations of fact and closing arguments.

[1] Effective September 1, 2005, the functions of the Commission were transferred to the newly-created Division of Workers' Compensation at the Texas Department of Insurance.

The parties attached documents to their stipulations, and those documents are admitted as Exhibit A. In addition, 36 numbered exhibits were admitted into evidence during the preliminary hearing. The record closed on July 9, 2007.

III. DISCUSSION

The claimant's surgery involved bilateral laminectomies with foraminotomies and anterior, lateral transverse, and posterolateral facet fusions at three levels. The surgery was performed on November 8, 2001, and the only medical information in the record after that date is a discharge summary prepared by the claimant's surgeon.[2] Vista charged $205,284.74 for its services, including $113,072 for implants. TMIC paid Vista a total of $33,662.00 which included $5,590 for the claimant's room charge and $28,072 for implants. To calculate the reimbursement for implants, TMIC obtained a copy of Vista's invoice and paid the invoice amount plus ten percent.[3]

Jim E. Bryant, Vista's Chief Executive Officer, confirmed that Vista received most implants on consignment.[4] The vendor took the implants, fusion cages, and pedicle screws to the facility no earlier than the night before the surgery, and the implants were kept in a sterile corridor.[5] Even so, Mr. Bryant asserted the markup was reasonable because Vista had higher *labor costs* than other hospitals. Non-profit hospitals generally have 3.0 to 3.2 and for-profit hospitals have 2.8 to 3.0 full-time employees per occupied bed. Vista had 5.0 or 6.0 employees per occupied bed because patient needs at Vista were higher.[6] In addition to labor costs, Mr. Bryant said Vista had non-labor costs for sterilizers, boilers, steam lines, filters, air conditioning, and electrical expenses.[7] To cover these costs, Vista not only marked up implantables, Vista marked up medical and surgical supplies 500 percent for items costing more than $100, and 700 percent for items costing less than $100.[8] Every

[2] The discharge summary shows a discharge date of September 15, 2001, but the summary also shows it was dictated on February 28, 2002, more than five months after the claimant's discharge.

[3] Ex. A, p. TMIC 200.

[4] Ex. 23, p. 25.

[5] *Id.*, pp. 26-27.

[6] *Id.*, pp. 56, 108.

[7] *Id.*, p. 43.

[8] *Id.*, pp. 62, 221.

item, no matter what the cost to Vista, was charged to insurers at a minimum of $3, Mr. Bryant said.[9]

For this claimant, Vista billed room and board charges at the rate of $650 per day for 16 days. Vista's bill also included $12,500 for "OR Services," $8,000 for operating room services, $10,607 for anesthesia services, and $6,240 for the two hours the claimant spent in a recovery room. According to Mr. Bryant, Vista billed operating and recovery room minutes to cover *total salaries* per year.[10] But for the year 2001, Mr. Bryant could not state what Vista's total charges as a percent of its total costs (charge-to-cost ratio) were.[11]

The claimant's surgeon, Eric Scheffey, M.D., required a neurological evaluation prior to performing surgery. However, it is not clear why the claimant had to be hospitalized two days before her surgery.[12] In addition to the operative report, Dr. Scheffey made progress notes for certain dates the claimant was hospitalized. His notes show:

> Nov. 8 – the claimant had no fever, her vital signs were stable, and she had some wound drainage;
>
> Nov. 13 – the claimant had no fever, her vital signs were stable, she had great discomfort but was walking and anxious to go home;
>
> Nov. 14 – the claimant had no fever, her vital signs stable, and she had some wound drainage;
>
> Nov. 15 – the claimant had no fever, her vital signs were stable, she had some wound drainage, she was ambulating well, and her pain was well-controlled with medication;
>
> Nov. 17 – the claimant had no fever but she was on IV antibiotics and had wound drainage;
>
> Nov. 19 – the claimant had fever the night before (99.6), and a culture showed she had Streptococcus viridans;

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[9] *Id.*, p. 66.

[10] *Id.*, p. 137.

[11] *Id.*, p. 137.

[12] The parties stipulated that the hospitalization began November 6, 2001, but Dr. Scheffey's notes indicate she was hospitalized November 5, 2001, three days prior to surgery. Ex. A, p. RD-274.

Nov. 20 – the claimant had no fever, she was to have a CBC, she had some continued pain in her back and legs, and she was ambulating well. Dr. Scheffey added, "She is here today for evaluation";

Nov. 21 – the claimant had a temperature of 99, her wound was starting to dry up without evidence of drainage, and she was feeling and ambulating better.

The parties stipulated that Vista's services were not unusually costly and extensive in comparison to the services normally rendered to patients having the same surgery but were unusually costly and extensive in comparison to services rendered for simpler surgeries, such as hernia repair. TMIC argued that Vista's charges exceeded the stop-loss threshold only because Vista inflated them. TMIC cited evidence of the amounts charged for the same diagnosis related group (DRG) at other Harris County hospitals. While Vista's charges in this case totaled $205,284.74, other Harris County hospitals charged an average of $47,975 for inpatient care for the same DRG (497).[13]

Vista contended that once the stop-loss threshold of $40,000 is reached, the provider qualifies for stop-loss reimbursement at 75 percent of the amount charged.[14] The provider need not meet any additional requirement. In addition, even if Vista is required to prove its services were unusually extensive and costly, a back surgery is among the most complex surgeries performed. Thus, Vista has demonstrated that it should be reimbursed using the stop-loss method.

IV. ANALYSIS

The stop-loss method of reimbursement is allowed on a case-by-case basis for unusually extensive and costly services when a hospital's total audited charges exceed the $40,000 stop-loss threshold. The ALJ finds that TMIC met its burden of proving that Vista is not entitled to stop-loss reimbursement. As reflected in the evidence, Vista's charges exceeded the stop-loss threshold because of Vista's markups – not because Vista's services were unusually extensive or costly.

[13] Ex. A, p. RD-27, attachment 3, figure 3.

[14] 28 TAC § 134.401(b)(1)(H) and (c)(6)(A)(i).

Vista used its operating and recovery charges to cover total salaries for the year and then marked up implantables and other supplies from 400 to 700 percent to cover facilities and equipment costs and, again, to cover salaries. There was no evidence regarding Vista's charge-to-cost ratio. Further, other hospitals provided surgery and admission services for the same DRG at the average rate of $47,975.

Since the DRG is some evidence that this type of surgery is unusually costly and since the claimant's surgery involved fusions at multiple levels, the ALJ might have made a different decision but for two facts. TMIC's auditor based TMIC's payment for implantables on an actual invoice. Therefore, the implantables cost less than $28,072.

Secondly, the record does not demonstrate why the claimant was hospitalized for so long. She did not develop Streptococcus viridans until about ten days after her surgery. By November 15, 2001, a week after her surgery, the claimant had no fever, her vital signs were stable, she was ambulating well, and her pain was well-controlled with medication.

Accordingly, the ALJ finds that Vista should be reimbursed using the *per diem* method. The parties stipulated that, if the *per diem* payment method described in 28 TAC § 134.401 applies to this admission, the correct amount of reimbursement is the amount TMIC has already paid Vista.

V. FINDINGS OF FACT

1. A workers' compensation claimant was injured on _____, while working for an employer who carried workers' compensation insurance with Texas Mutual Insurance Company (TMIC).

2. On November 6 through 22, 2001, the claimant was admitted to Vista Medical Center Hospital (Vista) where she underwent back surgery on November 8, 2001, to treat her work-related injury

3. The claimant's surgery involved bilateral laminectomies with foraminotomies at vertebral levels L2 though S2, anterior fusion from a posterior approach at L4-L5 and L5-S1, and lateral transverse and posterolateral facet fusion at L4-L5, L5-S1, and S1-S2.

4. The claimant experienced minimal blood loss during surgery and tolerated the procedure well.

5. Nothing unexpected or unusual occurred during the surgery or subsequent hospitalization.

6. The claimant was discharged from Vista on November 22, 2001.

7. Vista charged $205,284.74 for its services, including $113,072 for implants.

8. TMIC paid Vista a total of $33,662.00.

9. By November 15, a week after her surgery, the claimant had no fever, her vital signs were stable, she was ambulating well, and her pain was well-controlled with medication.

10. To calculate the reimbursement for implants, TMIC obtained a copy of Vista's invoice and paid the invoice amount plus ten percent, $28,072.

11. Vista received implants on consignment no earlier than the night before a surgery.

12. Vista marked up medical and surgical supplies five times their cost if the item cost more than $100 and seven times their cost if the item cost less than $100.

13. Every item, no matter what the cost to Vista, was charged to insurers at a minimum of $3.

14. Vista marked up implantables to cover what it said were higher labor costs.

15. For this claimant, Vista billed room and board charges at the rate of $650 per day for 16 days.

16. Vista billed $12,500 for "OR Services," $8,000 for operating room services, $10,607 for anesthesia services, and $6,240 for the time the claimant spent in a recovery room.

17. Vista marked up its operating and recovery room minutes to cover total salaries per year.

18. There was no evidence of what Vista's total charges as a percent of its total costs (charge-to-cost ratio) were.

19. The parties stipulated that, if the *per diem* payment method described in 28 TAC § 134.401 applies to this admission, the correct amount of reimbursement is $33,662.00 which is the amount TMIC has already paid Vista.

20. On October 30, 2002, Vista filed a request with the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission).

21. In a decision dated July 19, 2004, MRD granted Vista's request for additional reimbursement of $120,301.55, and TMIC requested a contested case hearing before the State Office of Administrative Hearings (SOAH).

22. Notice of the hearing on the appeal, dated August 26, 2004, was sent to both parties. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

23. On September 9, 2004, this case was consolidated with Docket No. 453-03-2412.M4, for the purpose of resolving threshold legal issues.

24. Order No. 14 in Docket No. 453-03-2412.M4 was issued November 22, 2005. The order resolved legal issues pertaining to this case and advised the parties to request hearing dates.

25. Based upon the parties' joint request, this docket was abated from February 21, 2006, to April 4, 2007, when the case was reinstated on the docket.

26. After the case was reinstated on the docket, the parties elected to file written stipulations of fact and closing arguments, rather than having a contested case hearing.

27. Attorneys Thomas B. Hudson, Jr., and Christopher H. Trickey represented TMIC, and attorney David F. Bragg represented Vista.

VI. CONCLUSIONS OF LAW

1. The Commission had, and the Division of Workers' Compensation at the Texas Department of Insurance has, jurisdiction over this matter pursuant to § 413.031 of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. ch. 401 *et seq*.

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

3. TMIC had the burden of proof in this case. 28 TEX. ADMIN. CODE (TAC) § 148.14.

4. TMIC met its burden of proving that Vista's services were not unusually extensive or costly.

5. Vista should be reimbursed using the *per diem* method. 28 TAC § 134.401(c).

6. TMIC has appropriately reimbursed Vista for the claimant's hospitalization. 28 TAC § 134.401(c).

ORDER

IT IS, THEREFORE, ORDERED that Texas Mutual Insurance Company's appeal is granted, and the insurer is not required to provide additional reimbursement to Vista Medical Center Hospital.

SIGNED September 7, 2007.

SARAH G. RAMOS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS