SOAH DOCKET NO. 453-05-6546.M4
MDR NO. M4-03-6199-01

VISTA MEDICAL CENTER HOSPITAL, Petitioner	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
TPCIGA FOR CREDIT GENERAL INDEMNITY COMPANY, Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Vista Medical Center Hospital (Provider) and TPCIGA[1] for Credit General Indemnity Company (Carrier)[2] both requested a hearing to contest a decision by the Medical Review Division (MRD) of the Texas Department of Insurance, Division of Workers' Compensation (Division)[3] denying additional reimbursement 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 (1997 ACIHFG).[4] The Administrative Law Judge (ALJ) finds the Stop-Loss Exception should be followed in this proceeding. Carrier is ordered to pay additional reimbursement in the amount of $25,607.13, plus any applicable interest.

[1] Texas Property Casualty Insurance Guaranty Association.

[2] Carrier is an impaired insurer under TEX. INS. CODE ANN. § 21.28-C.

[3] 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.

[4] 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.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on April 21, 2005. Provider filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the parties. The hearing convened and concluded on February 28, 2008.[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 $157,830.39[6] based on Provider's usual and customary charges for the inpatient stay and surgical procedure. To date, Carrier has paid $34,981.82.

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	$97,293.04	$97,293.04	$97,293.04	**$97,293.04**
After Reductions	Less than $40,000.00[7]	$97,293.04[8]	$34,981.82[9]	**$80,785.27[10]**

[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.

[6] At the hearing, Provider reduced its bill to $97,293.04 based on its discovery of duplicate charges.

[7] MRD determined that the services were unusually extensive. However, it agreed with Carrier's reductions for implantables to cost plus 10 percent and its audit for excessive charges, unbundling, undocumented charges, and unrelated charges. MRD concluded that the Stop-Loss Exception did not apply because these reductions brought Provider's bill below $40,000.00. It found that Carrier owed no additional reimbursement.

Reimbursement Methodology	per diem	x 75%	unknown	**x 75%**
Reimbursement Amount	Unstated	$72,969.78	$34,981.82	**$60,588.95**
Less Payment	($34,981.82)	($34,981.82)	($34,981.82)	**($34,981.82)**
Balance Due Provider	$0.00	$34,987.96	$0.00	**$25,607.13**

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."[11] The following legal issues in this

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[8] Provider contended it is entitled to reimbursement according to the Stop-Loss Methodology at 75 percent of total audited charges. It reduced its total charges by $60,537.35, from $157,830.39 to $97,293.04, based on its discovery of duplicate charges. It also agreed to reduce its charges by $124.20 for services unrelated to the compensable injury. Based on those reductions, it contended its total reimbursement should be $72,876.63, after applying the Stop-Loss Methodology ($97,293.04 - $124.20, $97,168.84 x .75, $72,876.63).

Provider elicited testimony from Rita Morales, the supervisor of the medical dispute and workers' compensation collection department at Doctor's Practice Management (DPM), a company that issues bills for hospitals, including Provider. Ms. Morales said Provider's bill reflects its usual and customary charges. She testified that she was not employed at DPM at the time of charges were made in May 2002 (she began working at DPM in July 2002) that a charge master, from which Provider's charges are taken, has changed over time; that she had never seen the May 2002 charge master; and that she had not compared the charges in this case with the charge master in effect in May 2002. She also said Provider's bills are always taken from the charge master; there is limited access to the charge master; and no charges are input manually. She said DPM reviews all services to make sure they are correctly input into the charge master.

[9] Carrier reduced Provider's charge for implantables, unbundling,, undocumented charges, and unrelated charges. Its bills are prepared by Corvel Corporation (Corvel). Chrsti Averitt, the supervisor of Corvel's medical review and quality control department, testified regarding some of the reductions to Provider's bill. Some charges were reduced for unbundling because they were a routine supply or service that should have been included in a global charge with other services. An example is Provider's bill for both anesthesia equipment and anesthesia time. She said pharmacy and laboratory charges were reduced on the same basis. Corvel follows Medicare guidelines to determine improper unbundling.

[10] The ALJ finds as follows: (1) Ms. Morales' testimony established that Provider charged its usual and customary charge by showing that all services are charged at a standard rate determined from the charge master; (2) Provider's charges should be reduced by the amount Provider acknowledged as duplicates and by the $124.20 it agreed were unrelated charges. This amounts to $60,661.55. (Provider's duplicate-charge reductions included all of Carrier's reductions for duplicates.) (3) Provider's charges should be reduced for unbundling as urged by Carrier, including pharmacy and lab charges, because Carrier presented probative evidence that the charges were improperly unbundled--Provider presented no contrary evidence. This amounts to $16,203.00. (4) Provider's charges should be reduced by the amount of certain items Corvel identified as potentially being charged in error, with further documentation needed. Most of the items Corvel identified in this category were included in Provider's reduction for duplications. However, Robaxin 1mg/NS100ml at $165.57, a tennis ball at $12.00, and a specimen container at $3.00 were not included. Provider's Ex. 1 at 5, 12, 33, 34, and 36. The MRD decision was against Provider. Once Carrier identified these items as needing further documentation, the burden was on Provider to show they were properly documented. The ALJ could not find documentation of these items, which total $180.57. (5) Applying the Stop-Loss Exception to these amounts ($157,830.39 minus $60,537.35 minus $124.20 minus $16,203.00 minus $180.57 equals $80,785.27 times .75) results in total reimbursement of $60,588.95. Subtracting the $34,981.82 already paid leaves $25,607.13 owed.

[11] 28 TAC § 134.401(c)(6).

case were decided by a SOAH En Banc Panel[12] (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 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.

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 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 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.[13]

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 charged its usual and customary charges for the items and services provided.

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.

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

[13] 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.

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

III. FINDINGS OF FACT

1. Claimant sustained a compensable injury in the course and scope of her employment; her employer had coverage with TPCIGA for Credit General Indemnity Company (Carrier).

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

3. Provider submitted itemized billing totaling $157,830.39 for services provided to Claimant.

4. Provider later reduced its charges by $60,537.35 to $97,293.04 because of duplicate billing.

5. The amount billed was Provider's usual and customary charge for these items and treatments.

6. Carrier issued payments of $34,981.82 to Provider for the services in question.

7. Carrier denied further reimbursement to Provider.

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

9. 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.

10. MRD issued its Findings and Decision holding that no additional reimbursement was owed Provider.

11. Both Provider and Carrier timely filed a request for a contested case hearing on the MRD's decision.

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

13. On February 28, 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 that day and the record closed on February 28, 2008.

14. Provider's total audited charges under § 134.401(c)(6)(A)(v), after additional appropriate reductions, are $80,785.27, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

15. Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $60,588.95. After deduction of Carrier's prior payment of $34,981.82, Provider is entitled to additional reimbursement of $25,607.13, 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. 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. Provider 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. 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.

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

14. 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.

15. 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.

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

17. Applying the Stop-Loss Methodology in this case, Provider is entitled to total reimbursement of $60,588.95.

18. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $34,981.82 of this amount.

19. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $25,607.13, plus any applicable interest.

ORDER

It is hereby **ORDERED** that TPCIGA for Credit General Indemnity Company reimburse Vista Medical Center Hospital the additional sum of $25,607.13, plus any applicable interest, for services provided to Claimant.

SIGNED April 23, 2008.

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