SOAH DOCKET NO. 453-05-6803.M4
MDR NO. M4-04-7893-01

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

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 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).[2] The Administrative Law Judge (ALJ) finds the Stop-Loss Exception should be followed in this proceeding. Accordingly, Liberty Mutual Fire Insurance Company (Carrier) is ordered to pay additional reimbursement in the amount of $20,782.59, plus any applicable interest.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on April 28, 2005. Provider filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the

[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.

parties. The hearing convened and concluded on February 26, 2008.[3] The record closed that same day.

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 $104,054.79 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. To date, Carrier has paid $56,420.00.

A. Issues

1. Summary of Positions and ALJ's Decision

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

[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.

	MRD	Provider	Carrier	ALJs
Charges	$104,054.79	$104,054.79	$104,054.79	**$104,054.79**
Post-Audit Charges	N/A	$104,054.79	unknown[4]	**$102,936.79**[5]
Reimbursement Methodology	per diem[6]	x 75%	modified Stop-Loss[7]	**x 75%**
Reimbursement Amount	$56,420.00	$78,041.09	$56,420.00	**$77,202.59**
Less Payment	($56,420.00)	($56,420.00)	($56,420.00)	**($56,420.00)**
Balance Due Provider	$0.00	$21,621.09	$0.00	**$20,782.59**[8]

[4] Although Carrier's April 26, 2004 letter to MRD explains its reductions, the post-audit charges are not readily computable because of an error in the implant charges used by Carrier. Carrier states total charges were $104,054.79 and that implantable charges, a component of the total charges, were $179,797.00.

[5] At the hearing on the merits, Carrier proposed that $1,118.00 should be deducted from Provider's charges to account for the initial day of the hospital stay because that day was not preauthorized. MRD found that one day of the hospital day was not preauthorized and Provider did not show that a nine-day stay was preauthorized. The ALJ finds that one day was not preauthorized and, as Provider did not contest Carrier's proposal to deduct $1,118.00 as the charges for that unauthorized day of stay, the ALJ has reduced Provider's total charges by $1,118.00.

[6] MRD determined that the Stop-Loss Exception did not apply since the admission did not involve "unusually extensive services." MRD did not calculate reimbursement. It simply stated that Carrier "correctly reimbursed" Provider $56,420.00 based on per diem reimbursement for an eight-day stay and the cost of implantables with invoice charges of $5,137.00.

[7] Carrier's September 2003 Explanation of Benefits (EOB) used an "F" denial code on all charges with an alpha-numeric modifier. For all charges except 8-days room and board, the Z695 modifier explained that the charges were reduced based on the fee schedule. For the 8-days room and board, the X388 modifier stated preauthorization was requested but denied. Carrier's April 26, 2004 letter to MRD states the charges for implantables were excessive and were subtracted from total charges. Carrier then re-priced the implantables at usual and customary for the geographic area and added back the remainder of the charges. Carrier's letter also states it deleted $146.15 of charges in revenue code 270 as incidentals, and $1027.00 for frame kits in revenue code 270 as not medically necessary. Carrier's letter states it reduced the following charges to usual and customary: (1) $9,200.00 for autologous growth factor (revenue code 361) to $1,500.00; (2) $379.25 for walker with wheels (revenue code 270) to $114.25; (3) $2,041.00 for symphony machine and kit (revenue code 272) to $450.00; (4) $5,125.00 for LSO (revenue code 270) to $1,025.00; and (5) $20,552.00 for two ray fusion cages (revenue code 278) to $6,380.00. Carrier states it paid the remainder of the charges at 75% of billed charges.

[8] The Stop-Loss Threshold was met in this case and the reimbursement should be calculated according to the Stop-Loss Exception. The reduction of charges to usual and customary for a geographic area is not a proper audit reduction under the Stop-Loss Exception. The balance of the reductions were not adequately specified or properly coded so as to place the Provider on adequate notice as to the basis for Carrier's denial in accordance with the regulatory requirements including 28 TAC §' 133.307(j)(2).

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."[9] The following legal issues in this case were decided by a SOAH En Banc Panel [10] (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.[11]

[9] 28 TAC § 134.401(c)(6).

[11] 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.

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. [12] 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.

III. FINDINGS OF FACT

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

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

3. Provider submitted itemized billing totaling $104,054.79 for services provided to Claimant.

4. The $104,054.79 billed was Provider's usual and customary charges for these items and treatments.

5. Carrier issued payments of $56,420.00 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).

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

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 26, 2008, Administrative Law Judge Howard S. Seitzman 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 that day.

13. One day of the nine-day hospital stay was not preauthorized and the Provider's total charges are reduced by $1,118.00 to account for that unauthorized day.

14. Provider's total audited charges under § 134.401(c)(6)(A)(v) are $102,936.79 , 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 $77,202.59. After deduction of Carrier's prior payment of $56,420.00, Provider is entitled to additional reimbursement of $20,782.59, 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 $77,202.59.

18. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $56,420.00 of this amount.

19. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $20,782.59, plus any applicable interest.

ORDER

It is hereby **ORDERED** that Liberty Mutual Fire Insurance Company reimburse Vista Medical Center Hospital the additional sum of $20,782.59, plus any applicable interest, for services provided to Claimant. All relief not expressly granted herein is **DENIED**.

SIGNED April 1, 2008.

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HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS