SOAH DOCKET NO. 453-05-7326.M4
MDR NO. M4-05-0212-01

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

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 Insurance Company (Carrier) is ordered to pay additional reimbursement in the amount of $35,017.96, plus any applicable interest.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on May 10, 2005. Provider filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the parties.

[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.

The hearing convened and concluded on May 29, 2008.[3]

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 $50,156.34 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. To date, Carrier has paid $2,236.00.

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	$50,156.34	$50,156.34	$50,156.34	**$50,156.34**
Adjusted Charges		$50,156.34		**$49,671.94**[4]

[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] The reductions in Carrier's audited charges are explained below in footnote 8.

	MRD	Provider	Carrier	ALJ
Reimbursement Methodology	per diem[5]	x 75%[6]	per diem[7]	**x 75%**[8]

[5] MRD determined that the Stop-Loss Exception did not apply since the admission did not involve "unusually extensive services." It calculated total reimbursement based on the per diem methodology (2 days " $1,118.00 per day ,$2,236.00). Based on Carrier's $2,236.00 payment, MRD concluded that Carrier owed no additional reimbursement.

[6] Provider contended it is entitled to reimbursement of $35,381.26 based on total audited charges of $50,156.34 x 75% , $37,617.26 - Carrier's $2,236.00 payment , $35,381.26. Provider noted that Carrier used denial codes "G," "N," "R," and "U," in addition to denial code "F". It asserted that because Carrier failed to request additional documentation within 14 days of its receipt of the medical bill, as required by 28 TAC § 133.301(d)(5), it waived the "N" ground for denying Provider's claim. It contended that Carrier's reasons for denial under codes "G," "R," and "U" were inadequate under 28 TAC § 133.304(c), in effect at the time of the dispute, which requires insurers to state their grounds for denial sufficiently for providers to understand their reasons for denying a claim.

[7] Carrier reimbursed $2,236.00 for room and board. It denied most other charges using an "F" denial code, explained as "the charge for this procedure exceeds the health facility fee schedule assigned by the Texas Workers Compensation Commission" or "the charges for this hospitalization have been reduced based on the fee schedule allowance." It denied a $23.00 lab fee using denial code "G X668," explained as "venipuncture charges are included in the global lab fees"; a $287.50 cardiology charge using denial code "R X206, explained as "this service is for a condition(s) which is not related to the covered work related injury;" an $81.90 charge for medical surgical supplies under denial code "U X017," explained as "this payer does not pay for personal items," and described as "urinal pitchur, toothbrush, paste, basin, tissue, denture cup, shampoo, soap, property bag, lotion, cups, and slippers – not payable under work comp;" and a $92.00 charge for medical surgical supplies under denial code "N X322," explained as "documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." (Carrier Ex. 1 at 17-20). Carrier denied, under denial code "F," a $9,200.00 Autologous Growth Factor, as "included in the surgical per diem and not paid separately" and "charges included in the facility fee." It denied three other services that the ALJ could not identify in Provider's billing, $265.00 for a "second walker billed – not medically necessary or usual and customary," $4,462.50 for "items denied as included in facility fee (sheets, video, video monitor, Wilson table, monitor, bouffant cap, shoe covers, pillow, camera, gowns, tongue depressor, and tennis balls),"and $3,066.00 for a "Process Disp Kit – denied as included in the surgical per diem and not paid separately." (Carrier Ex. 1 at 17-20.)

[8] Carrier's denial of the $23.00 charge for venipuncture and the $81.90 charge for medical surgical supplies described as personal items were adequately identified and explained. Provider had the burden of proof. Because Provider failed to prove that these items should be paid, its bill is reduced by those amounts. The $287.50 cardiology charge is not included in the audited charges because the State Office of Administrative Hearings does not have jurisdiction to decide whether a service is related to the compensable injury. Carrier's denial of $92.00 for medical surgical supplies was adequately identified and explained. Provider failed to prove those items should be paid. Provider's contention that Carrier waived this ground for denial by not requesting additional documentation within 14 days, as required by 28 TAC § 133.301(d)(5), was not persuasive because, in contrast to such rules as Rule 133.307(j)(2) (and statutes such as § 409.021(c) of the Labor Code), no consequences are stated for a failure to comply with this rule. The expressly stated waiver in the Division's rules concerning an insurance carrier's failure to act in a timely fashion in asserting its reasons for denial is contained in Rule 133.307(j)(2), which says a ground for denial that was not asserted before a request for medical dispute resolution may not be considered. The Division could have included a waiver in Rule 133.301(d), but did not. The best construction of Rule 133.301(d)(5) is that an insurer's failure to comply provides a basis for disciplinary action, but not a waiver. Overall, Carrier's audited charges are reduced by $484.40.

Carrier's general use of denial code "F," is inconsistent with the Stop-Loss Methodology, which requires payment of 75 percent of total audited charges. Carrier's specific reference under "F" to the $9,200.00 charge for the Autologous Growth Factor as included in the surgical per diem is inconsistent with the Stop-Loss Exception which requires payment at 75 percent of total audited charges, rather than payment on a per-diem basis. Carrier's denials of the $265.00 second-walker charge, the $4,462.50 for various items, and $3,066.00 charge for a "Process Disp Kit" appear to be based on either that they are included in the per-diem reimbursement methodology or as exceeding the usual and customary charge for the procedure. In either case, the denials are inconsistent with the Stop-Loss Methodology, which requires payment at 75 percent of Provider's usual and customary charges when those charges exceed $40,000.00.

	MRD	Provider	Carrier	ALJ
Reimbursement Amount	$2,236.00	$37,617.26	$2,236.00	**$37,253.96**
Less Payment	($2,236.00)	($2,236.00)	($2,236.00)	**($2,236.00)**
Balance Due Provider	$0.00	$35,381.26	$0.00	**$35,017.96**

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).

[9] 28 TAC § 134.401(c)(6).

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

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]

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 Insurance Company (Carrier).

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

3. Provider submitted itemized billing totaling $50,156.34 for services provided to Claimant.

4. The $50,156.34 billed was Provider's usual and customary charges for these items and treatments.

5. Carrier issued payments of $2,236.00 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.

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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.

12 Letter from ALJ Catherine C. Egan dated February 23, 2007.

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 May 29, 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 May 29, 2008.

13. Provider's total audited charges under § 134.401(c)(6)(A)(v), after appropriate reductions, are $49,671.94, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

14. Under the Stop-Loss Methodology and in accordance with its request to MRD, Provider is entitled to additional reimbursement of $35,017.96, plus any applicable interest.

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)(6) 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 $37,253.96.

18. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $2,236.00 of this amount.

19. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $35,017.96, plus any applicable interest.

ORDER

It is hereby **ORDERED** that Liberty Mutual Insurance Company reimburse Vista Medical Center Hospital the additional sum of $35,017.96, plus any applicable interest, for services provided to Claimant.

SIGNED July 22, 2008.

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