SOAH DOCKET NO. 453-05-7911.M4
MDR NO. M4-04-3954-01

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

DECISION AND ORDER

Vista Medical Center Hospital (Provider) and Zenith Star Insurance Company (Carrier) both 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 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, Carrier is ordered to pay additional reimbursement in the amount of $30,231.44, plus any applicable interest.

[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

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on June 13, 2005. Both Provider and Carrier filed timely and sufficient requests for hearing. Notice of the hearing was appropriately issued to the parties. The hearing convened and concluded on March 25, 2008.[3] To allow corrections to Provider's charges, the record remained open until March 28, 2008.

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 $60,268.25 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. To date, Carrier has paid $4,645.25.

B. Issues

1. Summary of Positions and ALJ's Decision

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

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or the Stop-Loss Rule.

[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	$60,268.25	$60,268.25	$60,268.25	**$60,268.25**
Post-Audit Charges	N/A	$48,418.25[4]	$40,000.00 or less[5]	**$46,502.25**[6]
Reimbursement Methodology	per diem[7]	x 75%	per diem	**x 75%**[8]
	MRD	**Provider**	**Carrier**	**ALJs**
Reimbursement Amount	$4,472.00	$36,313.69	$36,313.69	**$34,876.69**
Less Payment	($3,354.00)	($4,645.25)	($4,645.25)	**($**4,645.25**)**[9]

[4] Prior to the close of the record, the parties agreed that Provider withdrew the following charges: (1) Video on December 12, 2002, for $2,428.00; (2) Video monitor tower on December 13, 2002, for $225.00; (3) Camera on December 13, 2008, for $661.00; and (4) Ray fusion cage on December 13, 2008, for $8,536.00. These items were raised in the March 3, 2003 peer review letter from Joel D. Wilk, M.D. The March 3, 2003 peer review letter was not admitted as a peer review but was considered to the extent it supported or explained valid denial codes. The ALJ notes the letter does not state Dr. Wilk's specialty or experience.

[5] Carrier contends the per diem methodology applies based on its determination that total audited charges do not exceed $40,000.00 and are below the Stop-Loss Threshold. Carrier's Explanation of Benefits (EOB) used "F " (payment based on per diem methodology), "G" (payment for the service was included in the per diem amount), "M" (payment reduced to fair and reasonable), "N" (the documentation does not appear to support the billed charges or the service billed), and "V" (payment denied because Carrier deems the treatment or service to be medically unreasonable and/or unnecessary based upon a peer review judgment) denial codes.

[6] The reduction of charges to fair and reasonable is not consistent with the Stop-Loss Exception and those reductions are invalid. The "G" code was used improperly to include items in the per diem reimbursement. Because the hospitalization was preauthorized, the "V" code denial was improper. Provider charged for two x-rays of the full spine ($275.00 each), one on December 13 and one on December 14. Provider also charged for 2 units of a portable x-ray ($230.00 each) on December 13. Carrier "N" coded the radiology charges and Dr. Wilk's letter states the operative note documents a single lateral x-ray showing no retained hardware. The ALJ finds documentation supported one portable x-ray unit and one x-ray on December 13, the day of surgery. Although Dr. Wilk refers to $120.00 in x-rays, no such charge is apparent on the itemized bill. The Stryker TPS drill ($661.00) and the Styker burr ($750.00) are not mentioned in the operative report and the surgery only actually involved the removal of hardware, the filling of screw holes with bone wax and the confirmation of solid fusion without additional bone remodeling, drilling or use of additional hardware. The ALJ removes those charges because those instruments were not used. The Symphony, autologous growth factor, and other items mentioned by Dr. Wilk are satisfactorily documented. Even if one accepted the "V" code as questioning the service as falling outside the scope of the preauthorized service, his letter fails to adequately identify why they would not fall within the scope of the preauthorized service given that the preoperative plan was to repair any pseudoarthrosis with instrumentation and autograft as needed.

[7] MRD determined that the Stop-Loss Exception did not apply since the admission did not involve "unusually extensive services." MRD stated that preauthorization was obtained for a four-day inpatient hospitalization and that reimbursement was to be made using the per diem methodology (4 days "$1,118.00, $4,472.00).

[8] The Stop-Loss Threshold was met in this case and the reimbursement for the preauthorized 4-day hospitalization should be calculated according to the Stop-Loss Exception.

[9] While the documentation submitted to MRD showed a payment of $3,354.00, the parties stipulated Carrier actually paid Provider $4,645.25.

Balance Due Provider	$1,118.00	$31,668.44	$0.00	**$30,231.44**

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

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[10] 28 TAC § 134.401(c)(6).

[11] 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.[12]

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.[13] 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 Zenith Star Insurance Company (Carrier).

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

3. Provider submitted itemized billing totaling $60,268.25 for services provided to Claimant.

4. Provider subsequently reduced its billed charges to $48,418.25.

5. The $48,418.25 billed was Provider's usual and customary charges for these items and treatments.

6. Carrier issued payments of $4,645.25 to Provider for the services in question.

7. Carrier denied further reimbursement to Provider.

[12] 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.

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

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 additional reimbursement beyond the initial $3,354.00 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 March 25, 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.

14. Provider's total audited charges under § 134.401(c)(6)(A)(v) are $46,502.25, 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 $34,876.69. After deduction of Carrier's prior payment of $4,645.25, Provider is entitled to additional reimbursement of $30,231.44, 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. Both Provider and Carrier 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. In this proceeding, the party seeking relief from adverse findings of MRD had the burden of proof on those issues 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 $34,876.69.

18. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $4,645.25 of this amount.

19. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $30,231.44, plus any applicable interest.

ORDER

It is hereby **ORDERED** that Zenith Star Insurance Company reimburse Vista Medical Center Hospital the additional sum of $30,231.44, plus any applicable interest, for services provided to Claimant. All relief not expressly granted herein is **DENIED**.

SIGNED May 9, 2008.

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