SOAH DOCKET NO. 453-05-8032.M4
MDR NO. M4-05-8377-01

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

DECISION AND ORDER

Liberty Mutual Insurance Company of Texas (Carrier) 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 to Twelve Oaks Medical Center (Provider) 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, but that Carrier owes Provider no additional reimbursement.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on July 24, 2005. Carrier 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 27, 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 $93,886.43 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. To date, Carrier has paid $51,404.40.

B. 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	ALJ
Charges	$93,886.43	$93,886.43	$93,886.43	**$93,886.43**
Audited charges	$64,672.58			**$93,826.43**[4]
Reimbursement Methodology	modified stop-loss[5]	modified stop-loss[6]	per diem[7]	**stop-loss**[8]
Reimbursement Amount	$48,504.44	$64,781.64	$51,404.40	**$64,740.24**
Less Payment	($51,404.40)	($51,404.40)	($51,404.40)	**($51,404.40)**
Balance Due Provider	$2,899.97	$13,377.24	$0.00	**$0.00**[9]

[4] This reduction in audited charges is explained below in footnote 8.

[5] MRD determined that the Stop-Loss Exception applied because the services were unusually extensive and the post-audit charges exceeded $40,000.00. MRD noted that Carrier questioned Provider's charges for implantables at $47,049.00 and that Carrier reimbursed Provider $9,809.33 for the implantables. MRD calculated the cost for implantables as $8,917.57, assuming that Carrier paid 110 percent of cost. Based on its experience that the normal mark-up for implantables is 200 percent, MRD allowed a $17,835.15 charge for implantables. It determined the audited charges for non-implantable reimbursement at $46,837.43 and added that amount to $17,835.15 (for implantables) to arrive at total audited charges of $64,672.58. It multiplied that amount by 75 percent to arrive at $48,504.44 as the amount owed. MRD subtracted the amount Carrier paid, $51,404.40, from the $48,504.44 amount it said was owed and ordered Carrier to pay the difference of $2,899.97. (The difference between $51,404.44 and $48,504.44 is actually one cent less, or $2,899.96. MRD's math was incorrect because subtracting the amount paid, $51,404.40, from the $48,504.44 amount owed results in a negative figure rather than the positive amount MRD ordered Carrier to pay.)

MRD noted that Carrier used a "U" denial code in its audit with a statement that the charge for that service is not usually billed. MRD said this denial reason is not permissible because the "U" denial code was not submitted to MRD by the parties as one of their positions.

[6] Provider said, under its contract with Carrier, it should actually be paid 69 percent of total audited charges. It calculated this amount as $64,781.64, which is $13,377.24 more than the $51,404.40 amount paid.

[7] The parties agreed that Carrier paid $51,404.40 in reimbursement. Carrier denied additional payments using denial code "F," explained as "The charges for this hospitalization have been reduced based on the fee schedule allowance" and "The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix;" and denial code "U," explained as "The charge for this procedure, material, and/or service is normally not billed" for a $60.00 item described as "patient convenience" and "personal items." (Carrier Ex. 1--the pages to Carrier's exhibit are unnumbered.)

[8] The Stop-Loss Exception applies since total audited charges exceed the $40,000.00 Stop-Loss Threshold. Carrier's denial code "F" reason for denial is inconsistent with the Stop-Loss Exception. Carrier's denial of $60.00 for personal items was adequately explained and provided before Provider's request for medical dispute resolution. Provider's total audited charges are reduced by that amount.

[9] Even though the Stop-Loss Exception applies and MRD incorrectly applied that rule by reducing Provider's charge for implantables in determining Provider's total audited charges, Provider is not entitled to more than MRD ordered because it did not appeal the MRD decision. Furthermore, because Carrier did appeal the MRD decision, it is entitled to a review of that decision. MRD's calculation ($48,504.44 - $51,404.40, a positive $2,899.97) is mathematically incorrect—the calculation should have resulted in a negative amount. Carrier owes no additional reimbursement.

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).

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]

[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.

[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.

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, because Provider's audited charges were in excess of $40,000, 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 of Texas (Carrier).

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

3. Provider submitted itemized billing totaling $93,886.43 for services provided to Claimant.

4. The $93,886.43 billed was Provider's usual and customary charges for these items and treatments.

5. Carrier issued payments of $51,404.40 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 additional reimbursement of $2,899.97 was owed Provider based on its determination that the amount it said Carrier owed, $48,504.44, less the amount it said Carrier paid, $51,404.40, results in that remainder.

10. Carrier timely filed a request for a contested case hearing on the MRD's decision.

11. Provider did not appeal the MRD decision.

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

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 May 27, 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 closed on May 27, 2008.

14. Provider's total audited charges under § 134.401(c) (6) (A) (v) are $93,826.43, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

15. Total audited charges are $93,826.43, after deducting $60.00 for personal items, which Carrier properly denied before Provider's request for medical dispute resolution.

16. Under its contract with Carrier, Provider is limited to 69 percent of total audited charges when the Stop-Loss Exception applies.

17. Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $64,740.24. Under the Stop-Loss Exception, Provider would be entitled to $13,899.87 in additional reimbursement, but, because it did not appeal the MRD decision, it is limited to the amount MRD ordered Carrier to pay.

18. MRD's calculation of the amount Carrier owed was mathematically incorrect.

19. Under a correct mathematical determination in accordance with MRD's statement of the amount owed and the amount paid, Carrier owes no additional reimbursement.

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. 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. Carrier 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 hospitals 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. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider no additional reimbursement.

ORDER

It is hereby **ORDERED** that Liberty Mutual Insurance Company of Texas owes Twelve Oaks Medical Center no additional reimbursement.

SIGNED July 18, 2008.

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