No. 09-0162

IN THE SUPREME COURT OF TEXAS

VISTA COMMUNITY MEDICAL CENTER, LLP, *et al.*,
Petitioners,

v.

TEXAS MUTUAL INSURANCE COMPANY, *et al.*,
Respondents..

On Petition for Review
From the Third Court of Appeals at Austin

APPENDIX TO BRIEF OF AMICUS CURIAE

INSURANCE COUNCIL OF TEXAS

Respectfully submitted,

John D. Pringle
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ATTORNEY FOR INSURANCE COUNCIL OF TEXAS

December 9, 2009

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VISTA COMMUNITY MEDICAL CENTER, LLP, *et al.*,
Petitioners,

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ATTORNEY FOR INSURANCE COUNCIL OF TEXAS

December 9, 2009

APPENDIX TO BRIEF OF AMICUS CURIAE
INSURANCE COUNCIL OF TEXAS

APPENDIX 1

TAB 1

JONW-597F

SOAH DOCKET NO. 453-06-0037.M4
TWCC MR NO. M4-05-8979-01

VISTA HOSPITAL OF DALLAS, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
AMERICAN HOME ASSURANCE COMPANY, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

JOINDER ORDER NO. 1
ABATING CASE

This case involves the application, if any, of the Texas Workers' Compensation Commission's Stop-Loss Methodology (Stop-Loss) The Stop-Loss cases are joined for purposes of organizing the disposition of these dockets.

All discovery is **ABATED** pending further orders.

The hearing on the merits set for **9:00 a.m. on October 10, 2005**, is **CONTINUED**.

SO ORDERED.

SIGNED October 5, 2005.

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

APPENDIX 2

TAB 2

STOP-LOSS LEGAL ISSUES CONSOLIDATED DOCKET
SOAH DOCKET NO. 453-03-1487.M4 (LEAD DOCKET)
(TWCC MR NO. M4-02-3850-01)

HARTFORD CASUALTY INSURANCE COMPANY, Petitioner	§	BEFORE THE STATE OFFICE
V.	§	OF
VISTA HEALTHCARE, INC., Respondent	§	ADMINISTRATIVE HEARINGS

CONSOLIDATED ORDER NO. 4 MEMORIALIZING PREHEARING CONFERENCE AND ISSUING BRIEFING OUTLINE

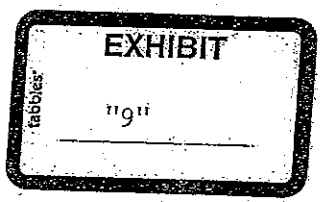
At 9:00 a.m. on June 28, 2006, the En Banc Panel (Panel) convened a prehearing conference to consider the request of certain parties to allow the introduction of evidence into these proceedings and other preliminary issues raised by the parties. The prehearing conference adjourned at 12:45 p.m.

A. After hearing the arguments of the parties and considering their pleadings, the Panel makes the following decisions:

1. The briefing outline attached as Appendix A is the briefing outline to be followed by the parties.

2. A new briefing schedule is set forth in Attachment B to this Order. Parties may submit briefs individually or jointly. The initial briefs will be limited to 50 pages, exclusive of the table of contents, rule appendices and case appendices. Reply briefs will be limited to 25 pages, exclusive of the table of contents, rule appendices and case appendices. All filings shall comply with the requirements of Consolidated Order No. 1. Failure to comply with the filing requirements may result in the SOAH docketing office rejecting the filing.

3. The parties may proceed with supplementing the depositions of David Martinez and Allen C. McDonald, Jr. The Martinez and McDonald depositions are admitted conditioned upon submission of the depositions, as supplemented, by 5:00 p.m. on August 22, 2006, and subject to objections filed by that date. All other discovery remains ABATED.



B The following tenders of evidence are denied:

1. Transcript of Hearing Regarding Threshold Legal Issues in Vista Consolidated Docket (ALJ Ramos, May 6, 2005–excerpts regarding testimony of Ron T. Luke, J.D., Ph.D., and Nicholas Tsourmas, M.D.

2. Video excerpts from a May 7, 2004 surgery performed by Nicholas Tsourmas, M.D. and his curriculum vitae.

3. The October 11, 2004 deposition of Jim E. Bryant, Jr., R.N.

4. The February 25, 2005 deposition of Janet Cheng.

5. The February 25, 2005 deposition of Jean Wincher.

6. The April 12, 2005 Report by Research & Planning Consultants, L.P.

C The Panel officially notices for the purpose of admitting into evidence:

1. All written decisions of the Texas Workers' Compensation Commission (Commission)[1] Medical Review Division resolving fee disputes between parties as to the application, if any, of the Stop-Loss exception to the Acute Care Hospital Fee Guideline (ACHFG)

2. Texas Register: 16 Tex. Reg. 3569 (1991) (emerg. rule 28 TEX. ADMIN. CODE § 134.400); 16 Tex. Reg. 3868 (1991) (withdrawal of emergency effectiveness of rule 28 TEX. ADMIN. CODE § 134.400); 17 Tex. Reg. 2246 (1992) (prop. new rule 28 TEX. ADMIN. CODE § 134.400); 17 Tex. Reg. 4949 (1992) (adopted 28 TEX. ADMIN. CODE § 134.400); 21 Tex. Reg. 6939 (1996) (prop. repeal of 28 TEX. ADMIN. CODE § 134.400 and prop. new 28 TEX. ADMIN. CODE § 134.401); 22 Tex. Reg. 1309 (1997) (withdraw prop. repeal of 28 TEX. ADMIN. CODE § 134.400 and prop. adoption of 28 TEX. ADMIN. CODE § 134.401); 22 Tex. Reg. 1579 (1997) (prop. new 28 TEX. ADMIN. CODE § 134.401 and prop. repeal of 28 TEX. ADMIN. CODE § 134.400); and 22 Tex. Reg. 6264 (1997) (adoption of 28 TEX. ADMIN. CODE § 134.401 and the repeal of 28 TEX. ADMIN. CODE § 134.400).

3. SOAH Decision and Orders: 453-97-0625 (1998 - ALJ C. Hayes); 453-00-2092 (2001 - ALJ G. Cunningham); 453-01-1612 (2001 - ALJ G. Cunningham); 453-02-1614 (2002 - ALJ S. Marshall); 453-03-0910 (2003 - ALJ K. Sullivan); 453-03-1233 (2003 - ALJ T. Walston); 453-03-1626 (2003 - ALJ W. Harvel); 453-03-1628 (2003 -

[1] Effective September 1, 2005, the Texas Workers' Compensation Commission became the Texas Department of Insurance, Division of Workers' Compensation (collectively Commission).

ALJ S. Rivas); 453-03-3120 (2003 - ALJ H. Seitzman); 453-03-3581 (2004 - ALJ B. Zukauckas); 453-04-3600 (2004 - ALJ C. Church); 453-04-4223 (2004 - ALJ H. Card); 453-04-4338 (2004 - ALJ T. Walston); 453-04-4455 (2004 - ALJ G. Elkins); 453-04-5367 (2005 - ALJ T. Walston); and 453-04-8285 (2005 - ALJ B. Zukauckas).

4. All opinions of the district and appellate courts of the state addressing the ACHFG and the application, if any, of the Stop-Loss exception.

5. The rules of the Commission as promulgated in the Texas Administrative Code.

6. The video excerpts from the Commission's public meetings of January 20, 2005 and February 17, 2005.

All relief not expressly granted herein is **DENIED**.

SO ORDERED.

SIGNED July 7, 2006.

Catherine C. Egan

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX A
REVISED STOP-LOSS EN BANC PANEL ISSUES BRIEFING OUTLINE

I. Eligible Items

ISSUE 1: How is the $40,000 Stop-Loss Threshold calculated? Are all eligible items included in the calculation of the $40,000 Stop-Loss Threshold or are items listed in 28 TAC § 134.401(c)(4) excluded in their entirety from the calculation? If included, how are the dollar amounts of 28 TAC § 134.401(c)(4) items calculated?

II. Reimbursement Rate

ISSUE 2: If an admission is eligible for Stop-Loss payment, is reimbursement at 75%, or are the items listed in 28 TAC § 134.401(c)(4) reimbursed other than at 75% of eligible amounts? If reimbursement for 28 TAC § 134.401(c)(4) is not at 75% of eligible amounts, how is reimbursement calculated?

III. Audit

ISSUE 3A: If a Carrier fails to audit the Hospital's charges in the manner required by the Commission's audit rules, may it subsequently challenge the hospital's charges?

ISSUE 3B: Is a carrier's audit limited to the scope of 28 TAC § 134.401(c)(6)(A)(v) or may it audit as per 28 TAC § 134.401(b)(2)(C)?

IV. Effect of 28 TAC § 134.401(c)(6)

ISSUE 4: If the total eligible amounts are in excess of $40,000, does that by itself establish eligibility for applying 28 TAC § 134.401(c)(6) and thereby satisfy the unusually costly/ unusually extensive language in the rule? Or, is there an additional requirement that any or all of the services also be unusually costly and unusually extensive? If the latter, must each service be unusually costly and unusually extensive or does the rule require that only one service be unusually costly or extensive?

V. Staff Report

ISSUE 5: What is the effect of the February 17, 2005 Staff Report?

ISSUE 5A(1): Is the February 17, 2005 Staff Report consistent with 28 TAC § 134.401(c)(6) (the Stop-Loss Rule)? If the February 17, 2005 Staff Report is not consistent with the Commission's Stop-Loss Rule, what is the effect of the February 17, 2005 Staff Report?

ISSUE 5A(2): Is the February 17, 2005 Staff Report consistent with the Commission's interpretation of its Stop-Loss Rule, as set forth in, but not limited to, 21 Tex. Reg. 6939-6945 (July 26, 1996); 22 Tex. Reg. 1579-1596 (February 11, 1997); and 22 Tex. Reg. 6264-6308 (July 4, 1997) and the Commission's written decisions issued by its Medical Review Division? If the February 17, 2005 Staff Report is not consistent with the Commission's interpretation of its Stop-Loss Rule, what is the effect of the February 17, 2005 Staff Report?

ATTACHMENT B
PROPOSED SCHEDULE

DEADLINE ITEM	DATE
Parties' Comments to Schedule	Noon on Friday, July 14, 2006.
Initial Briefs to be Filed at SOAH and Received by Parties	Friday, October 6, 2006, by 5:00 p.m.
Reply Briefs to be Filed at SOAH and Received by Parties	Friday, October 20, 2006, by 5:00 p.m.
Oral Argument Before En Banc Panel	Friday, November 3, 2006, at 10:00 a.m.

APPENDIX 3

TAB 3

Texas Mutual Insurance Company's Comments on Proposed Repeal of the 1997 Hospital Fee Guideline – 28 TEX. ADMIN. CODE § 134.401

Explain the Reasons for and Effect of Repeal of § 134.401 More Fully and Specifically

Texas Mutual urges the Division in its order of repeal to:

(1) explain the reasons for repeal in more detail than in the notice of proposed repeal, and

(2) explain the effect of repeal on pending fee disputes more specifically.

Explaining its reasons and the effect of repeal more fully will help the Division put the stop-loss exception debacle behind the Division, the hospitals, the carriers, and the courts.

If the Division fails to explain the reasons for and effect of repeal more fully, the Division will invite additional litigation.

Texas Mutual urges the Division to incorporate the substance of the following explanations into its final order of repeal.

Reasons for Repeal of the 1997 Hospital Fee Rule:

The Division's notice of proposed repeal states that: "Section 134.401 no longer meets the needs of the workers' compensation system. Since section 134.401 will no longer be needed after March 1, 2008, the Division proposes the repeal of section 134.401." 33 Tex. Reg. 1487 (Feb. 22, 2008).

1. The Division should more fully explain how repeal of the 1997 hospital fee rule is authorized or required by the Labor Code.

Repeal of a rule is rulemaking. In rulemaking, a Texas agency is required to supply a reasoned justification that must include "a concise restatement of the particular statutory provisions under which the rule is adopted and of how the agency interprets the provisions as authorizing or requiring the rule." TEX. GOV'T CODE § 2001.033(a)(2). The Division should more fully explain how repeal of the 1997 hospital fee rule is authorized or required by the Labor Code. Several reasons the Division can properly use in its explanation follow.

The 1997 rule is not Medicare-based – Effective as of 2002, Labor Code § 413.011 has required that Texas workers' compensation healthcare fee rules follow standardized Medicare reimbursement methodologies, models and relative weights and values. The 1997 hospital fee rule does not in any way track Medicare reimbursement methodologies, models and relative values for hospital inpatient services.

The 1997 hospital inpatient fee rule's standard payment methodology is per diem, with three levels for medical admissions, surgical admissions, and ICU/CCU, set in 1997. Medicare's

hospital inpatient reimbursement methodology provides cost-based reimbursement for each of numerous "diagnostic-related groups" of procedures, and the relative values of different procedures are determined using extremely detailed and current full cost information.

The 1997 hospital fee rule's "outlier" case payment method is the stop-loss exception. It does not tie outlier payments to hospital costs in outlier cases. Medicare's outlier payment method does tie outlier payments to outlier costs.

For admissions occurring on or after March 1, 2008, the Division adopted a new rule, 28 TEX. ADMIN. CODE § 134.403, which does comply with the Medicare-based reimbursement methodologies and relative value requirements of Labor Code § 413.011. But this new rule does nothing to cure the failure to have a Medicare-based rule in effect for admissions since 2002 and before March 1, 2008. Division data indicate that there are more than 1400 pending fee disputes concerning such admissions.

The 1997 hospital fee rule does not achieve effective medical cost control – The agency must also supply a reasoned justification for a rule, including a repeal, that states the "factual basis for the rule as adopted which demonstrates a rational connection between the factual basis for the rule and the rule as adopted," and "demonstrates in a relatively clear and logical fashion that the rule as adopted is a reasonable means to a legitimate objective" under the controlling statute. TEX. GOV'T CODE §§ 2001.033(a)(1)(B) and 2001.035(c). To ensure against a challenge to the repeal, the Division should more fully explain the ties between the facts and the statutory objectives of healthcare fee rules. Several explanations the Division can properly use follow.

Labor Code § 413.011 requires that Texas workers' compensation healthcare fee rules ensure effective medical cost control. Since at least 2005 the Division has recognized that the stop-loss exception, if it only requires total audited charges exceeding $40,000, is not a reasonable means to this statutory objective. On February 17, 2005, the Division released and implemented its Staff Report on "Agency Interpretation and Application of the Hospital Stop-Loss Reimbursement Method (Rule 134.401)."

The Staff Report noted that the stop-loss exception was from the beginning intended "to be used for 'unusually costly services' in admissions that involve 'unusually extensive services,'" and that it set a *threshold* of $40,000 in total audited charges.

The Staff Report recognized that at least as early as 2004 the $40,000 threshold no longer achieved effective medical cost control. "When the Commission initially adopted this rule, approximately 3% of workers' compensation hospitals stays met the threshold of $40,000. The charges associated with these hospital stays represented 17% of all billed hospital inpatient charges (excluding trauma cases). These few hospital stays were presumed to represent unusually extensive services. In reviewing the data for 2004, more than 28% of hospital stays met this threshold, representing more than 65% of all billed charges (excluding trauma cases). This large percentage increase indicates that a hospital charge of $40,000 or more is no longer, by itself, a good indicator that a hospital stay involves unusually extensive services."

The notice of proposed repeal alludes to these facts but does not finish the story, in two important ways.

First, $40,000 does not limit payment at 75% of total audited charges to unusually extensive services because hospitals set their own charges, unregulated. If there is no other limit than charges above $40,000, the stop-loss exception allows hospitals to require that they be paid more simply by the hospital charging more.

That does not achieve effective medical cost control. Indeed, it delegates the Division's government function of setting hospital payments to the hospitals themselves. Division data indicate that the amount in controversy (claimed by hospitals at 75% of charges in matters in which charges exceeded $40,000, less amounts paid at per diem plus carve-outs) in the more than 1400 pending fee disputes exceeds $70 million.

Second, the Division in the Staff Report dealt with the failure of the $40,000 total audited charge threshold to achieve medical cost control by adopting the interpretation that the 1997 fee rule authorized and required the Division to "determine whether or not the hospital stay involved unusually extensive services on a case-by-case basis." Vista challenged this interpretation. The Hon. Margaret Cooper ruled for Vista, and the Division has elected not to appeal.

Repeal of the 1997 hospital fee rule is therefore a reasonable, indeed required, means to address the statutory objective of effective medical cost control for all pre-March 1, 2008 admissions.

Effect of Repeal of the 1997 Hospital Fee Rule:

The Division's notice of proposed repeal states that: "Section 134.401 no longer meets the needs of the workers' compensation system. Since section 134.401 will no longer be needed after March 1, 2008, the Division proposes the repeal of section 134.401." 33 Tex. Reg. 1487 (Feb. 22, 2008). The Division clearly and understandably seeks to put the stop-loss exception debacle behind the Texas workers' compensation system, and intends repeal of the 1997 hospital fee rule for that purpose. The Division should more fully explain the effect of the repeal to avoid additional litigation and encourage settlements.

The Division's default rule will control pending cases – After the repeal of § 134.401, for admissions occurring before March 1, 2008 for which reimbursement has been timely disputed and the dispute has not been finally and non-appealably resolved, there will be no applicable fee guideline setting a specific maximum allowable reimbursement.

In such a case, Division rule § 134.1 applies. *All Saints Hospital System v. Texas Workers' Compensation Commission*, 125 S.W.3d 96 Tex. App. – Austin 2003, pet. denied).

Division rule § 134.1 subsections (c)(3)-(d) require that in the absence of an applicable fee guideline setting a specific MAR, fair and reasonable reimbursement must be "consistent with the criteria of Labor Code § 413.011."

Specifying the effect of repeal will discourage additional wasteful litigation – Vista and perhaps other hospitals may challenge the application of the default rule to the admissions before March 1, 2008 for which fee disputes are pending. The Division can and should reduce this litigation risk by specifying that the default rule controls.

The United States Supreme Court has held that " a court is to apply the law in effect at the time it renders its decision, unless doing so would result in manifest injustice or there is statutory direction or legislative history to the contrary." *Bradley v. School Board of Richmond*, 94 S.Ct. 2006, 2016 (1974).

There is nothing manifestly unjust about a hospital being paid a fee that is fair and reasonable under the statutory standards, as Division rule § 134.1 subsections (c)(3)-(d) require. The statutory standards define what is a fair and reasonable fee.

In the absence of clarification of the effect of the repeal, Vista and any allies may argue that, despite the repeal of the 1997 fee rule, there is direction or intent by the Division that the 1997 fee rule continue to control all admissions before March 1, 2008, and that Division rule § 134.1 subsections (c)(3)-(d) would not control still-pending fee disputes over admissions occurring before March 1, 2008.

The Division should dispose of this risk by including the following language in its repeal of 28 TEX. ADMIN CODE § 134.401:

"After the repeal of 28 Tex. Admin. Code. §134.401, for inpatient hospital admissions occurring before March 1, 2008 for which medical fee disputes are timely filed and pending at the Medical Review Division, at the State Office of Administrative Hearings, or in court, determinations whether additional payment is due will be governed by Division rule 134.1(c)(3)-(d), which makes applicable the Labor Code section 413.011 statutory reimbursement standards."

Clarifying that repeal applies to pending cases is necessary to moot the SLX litigation – Repeal of the 1997 hospital inpatient fee rule, resulting in application of the statutory standards pursuant to Division rule § 134.1(c)(3)-(d), will moot all pending stop loss exception litigation. Failure to make the repeal result in the application of Division rule § 134.1(c)(3)-(d) would mean that the litigation will continue for years more, and then end in the same way – application of Division rule § 134.1(c)(3)-(d).

After the Division's decision not to appeal, the core of the pending litigation is about the validity of the 1997 fee rule's stop-loss exception assuming that exception only requires hospital charges exceeding $40,000. Repeal making Division rule § 134.1(c)(3)-(d) control all fee disputes on pre-March 1, 2008 admissions moots that litigation.

If, however, Vista challenges the effectiveness of repeal to make Division rule § 134.1(c)(3)-(d) control all fee disputes on pre-March 1, 2008 admissions, and if Vista prevails, then it will be necessary for the courts to determine the validity of a rule that only requires that total audited charges exceed $40,000 and does not regulate charges. It will be at least 2009 and perhaps 2010

before the Third Court of Appeals issues its decision, and petitions for review by the Texas Supreme Court may postpone a final decision until 2011 and 2012.

Repeal specifying that Division rule § 134.1(c)(3)-(d) controls will encourage SLX settlements – If the Division specifies in repealing the 1997 hospital fee rule that Division rule § 134.1(c)(3)-(d) controls fee disputes over pre-March 1, 2008 admissions, and moots the pending litigation over the 1997 fee rule's exception, this will encourage prompt settlements of what is "fair and reasonable" payment for such disputes, at or near the Division's new Medicare-based fee rule fees.

This is the best hope the Division has to encourage settlements of the more than 1400 stop-loss exception fee disputes its data show as pending, at levels that the Division's new Medicare-based fee rule indicates are fair and reasonable.

John D. Pringle

From: Steve Nichols [snichols@insurancecouncil.org]
Sent: Monday, March 24, 2008 3:53 PM
To: RuleComments@tdi.state.tx.us
Cc: Albert.Betts@tdi.state.tx.us; Norma.Garcia@tdi.state.tx.us; Matthew.Zurek@tdi.state.tx.us; Mary.Landrum@tdi.state.tx.us; Rick Gentry; johndpringle@sbcglobal.net; Geoff Billings
Subject: Insurance Council of Texas Supplemental Comments on Proposed Repeal of the 1997 Hospital Fee Guideline - 28 TEX. ADMIN. CODE § 134.401
Importance: High

Commissioner Betts:

Please accept the following comments as ICT's supplemental comments on the proposed repeal of the Acute Care Inpatient Hospital Fee Guideline,

28 TEX. ADMIN. CODE § 134.401.

I would welcome an opportunity to meet with you to discuss the attached comments prior to action being taken on the proposed rule repeal. A formal

request for the meeting is included in the attached comments.

Respectfully,

Steven W. Nichols

Manager, Workers' Compensation Services

Insurance Council of Texas

Tel. No.: (512) 326-7618 or 444-9611

Fax. No.: (512) 444-0734

E-mail: snichols@insurancecouncil.org

Insurance Council of Texas Supplemental Comments on Proposed

Repeal of the 1997 Hospital Fee Guideline – 28 Tex. Admin. Code § 134.401

Explain the Reasons for and Effect of Repeal of § 134.401 More Fully and Specifically

The Insurance Council of Texas (ICT) urges Commissioner Betts in his order of repeal to:

(1) explain the reasons for repeal in more detail than in the notice of proposed repeal, and

(2) explain the effect of repeal on pending fee disputes more specifically.

Explaining its reasons and the effect of repeal more fully will help the Division of Workers' Compensation (DWC) put the stop-loss exception issue and disputes behind the DWC, the hospitals, the carriers, and the courts.

If the DWC fails to explain the reasons for and effect of repeal more fully, the DWC will invite additional litigation.

ICT urges the DWC to incorporate the substance of the following explanations into its final order of repeal.

Reasons for Repeal of the 1997 Hospital Fee Rule:

The DWC's notice of proposed repeal states that: "Section 134.401 no longer meets the needs of the workers' compensation system. Since section 134.401 will no longer be needed after March 1, 2008, the DWC proposes the repeal of section 134.401." 33 Tex. Reg. 1487 (Feb. 22, 2008).

1. The DWC should more fully explain how repeal of the 1997 hospital fee rule is authorized or required by the Labor Code.

Repeal of a rule is rulemaking. In rulemaking, a Texas agency is required to supply a reasoned justification that must include "a concise restatement of the particular statutory provisions under which the rule is adopted and of how the agency interprets the provisions as authorizing or requiring the rule." Tex. Gov't Code § 2001.033(a)(2). The DWC should more fully explain how repeal of the 1997 hospital fee rule is authorized or required by the Labor Code. Several reasons the DWC can properly use in its explanation follow.

The 1997 rule is not Medicare-based – Effective as of 2002, Labor Code § 413.011 has required that Texas workers' compensation healthcare fee rules follow standardized Medicare reimbursement methodologies, models and relative weights and values. The 1997 hospital fee rule does not in any way track Medicare reimbursement methodologies, models and relative values for hospital inpatient services.

The 1997 hospital inpatient fee rule's standard payment methodology is per diem, with three levels for medical admissions, surgical admissions, and ICU/CCU, set in 1997. Medicare's hospital inpatient reimbursement methodology provides cost-based reimbursement for each of numerous "diagnostic-related groups" of procedures, and the relative values of different procedures are determined using extremely detailed and current full cost information.

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For admissions occurring on or after March 1, 2008, the DWC adopted a new rule, 28 Tex. Admin. Code § 134.403, which does comply with the Medicare-based reimbursement methodologies and relative value requirements of Labor Code § 413.011. But this new rule does nothing to cure the failure to have a Medicare-based rule in effect for admissions since 2002 and before March 1, 2008. DWC data indicate that there are more than 1400 pending fee disputes concerning such admissions.

The 1997 hospital fee rule does not achieve effective medical cost control – The agency must also supply a reasoned justification for a rule, including a repeal, that states the "factual basis for the rule as adopted which demonstrates a rational connection between the factual basis for the rule and the rule as adopted," and "demonstrates in a relatively clear and logical fashion that the rule as adopted is a reasonable means to a legitimate objective" under the controlling statute. Tex. Gov't Code §§ 2001.033(a)(1)(B) and 2001.035(c). To

ensure against a challenge to the repeal, the DWC should more fully explain the ties between the facts and the statutory objectives of healthcare fee rules. Several explanations the DWC can properly use follow.

Labor Code § 413.011 requires that Texas workers' compensation healthcare fee rules ensure effective medical cost control. Since at least 2005 the DWC has recognized that the stop-loss exception, if it only requires total audited charges exceeding $40,000, is not a reasonable means to this statutory objective. On February 17, 2005, the DWC released and implemented its Staff Report on "Agency Interpretation and Application of the Hospital Stop-Loss Reimbursement Method (Rule 134.401)."

The Staff Report noted that the stop-loss exception was from the beginning intended "to be used for 'unusually costly services' in admissions that involve 'unusually extensive services,'" and that it set a *threshold* of $40,000 in total audited charges.

The Staff Report recognized that at least as early as 2004 the $40,000 threshold no longer achieved effective medical cost control. "When the Commission initially adopted this rule, approximately 3% of workers' compensation hospitals stays met the threshold of $40,000. The charges associated with these hospital stays represented 17% of all billed hospital inpatient charges (excluding trauma cases). These few hospital stays were presumed to represent unusually extensive services. In reviewing the data for 2004, more than 28% of hospital stays met this threshold, representing more than 65% of all billed charges (excluding trauma cases) This large percentage increase indicates that a hospital charge of $40,000 or more is no longer, by itself, a good indicator that a hospital stay involves unusually extensive services."

The notice of proposed repeal alludes to these facts but does not finish the story, in two important ways.

First, $40,000 does not limit payment at 75% of total audited charges to unusually extensive services because hospitals set their own charges, unregulated. If there is no other limit than charges above $40,000, the stop-loss exception allows hospitals to require that they be paid more simply by the hospital charging more.

That does not achieve effective medical cost control. Indeed, it delegates the DWC's government function of setting hospital payments to the hospitals themselves. DWC data indicate that the amount in controversy (claimed by hospitals at 75% of charges in matters in which charges exceeded $40,000, less amounts paid at per diem plus carve-outs) in the more than 1400 pending fee disputes exceeds $70 million.

Second, the DWC in the Staff Report dealt with the failure of the $40,000 total audited charge threshold to achieve medical cost control by adopting the interpretation that the 1997 fee rule authorized and required the DWC to "determine whether or not the hospital stay involved unusually extensive services on a case-by-case basis." Vista challenged this interpretation. The Hon. Margaret Cooper ruled for Vista, and the DWC has elected not to appeal.

Repeal of the 1997 hospital fee rule is therefore a reasonable, indeed required, means to address the statutory objective of effective medical cost control for all pre-March 1, 2008 admissions.

Effect of Repeal of the 1997 Hospital Fee Rule:

The DWC's notice of proposed repeal states that: "Section 134.401 no longer meets the needs of the workers' compensation system. Since section 134.401 will no longer be needed after March 1, 2008, the DWC proposes the repeal of section 134.401." 33 Tex. Reg. 1487 (Feb 22, 2008). The DWC clearly and understandably seeks to put the stop-loss exception debacle behind the Texas workers' compensation system, and intends repeal of the 1997 hospital fee rule for that purpose. The DWC should more fully explain the effect of the repeal to avoid additional litigation and encourage settlements.

The DWC's default rule will control pending cases – After the repeal of § 134.401, for admissions occurring before March 1, 2008 for which reimbursement has been timely disputed and the dispute has not been finally and non-appealably resolved, there will be no applicable fee guideline setting a specific maximum allowable reimbursement.

In such a case, DWC rule § 134.1 applies. *All Saints Hospital System v. Texas Workers' Compensation Commission*, 125 S.W.3d 96 Tex. App. – Austin 2003, pet. denied).

DWC rule § 134.1 subsections (c)(3)-(d) require that in the absence of an applicable fee guideline setting a specific MAR, fair and reasonable reimbursement must be "consistent with the criteria of Labor Code § 413.011."

Specifying the effect of repeal will discourage additional wasteful litigation – Vista and perhaps other hospitals may challenge the application of the default rule to the admissions before March 1, 2008 for which fee disputes are pending. The DWC can and should reduce this litigation risk by specifying that the default rule controls.

The United States Supreme Court has held that "a court is to apply the law in effect at the time it renders its decision, unless doing so would result in manifest injustice or there is statutory direction or legislative history to the contrary." *Bradley v. School Board of Richmond*, 94 S.Ct. 2006, 2016 (1974).

There is nothing manifestly unjust about a hospital being paid a fee that is fair and reasonable under the statutory standards, as DWC rule § 134.1 subsections (c)(3)-(d) require. The statutory standards define what is a fair and reasonable fee.

In the absence of clarification of the effect of the repeal, Vista and any allies may argue that, despite the repeal of the 1997 fee rule, there is direction or intent by the DWC that the 1997 fee rule continue to control all admissions before March 1, 2008, and that DWC rule § 134.1 subsections (c)(3)-(d) would not control still-pending fee disputes over admissions occurring before March 1, 2008.

The DWC should dispose of this risk by including the following language in its repeal of 28 Tex. Admin Code § 134.401:

"After the repeal of 28 Tex. Admin. Code. §134.401, for inpatient hospital admissions occurring before March 1, 2008 for which medical fee disputes are timely filed and pending at the Medical Review DWC, at the State Office of Administrative Hearings, or in court, determinations whether additional payment is due will be governed by DWC rule 134.1(c)(3)-(d), which makes applicable the Labor Code section 413.011 statutory reimbursement standards."

Clarifying that repeal applies to pending cases is necessary to moot the SLX litigation – Repeal of the 1997 hospital inpatient fee rule, resulting in application of the statutory standards pursuant to DWC rule § 134.1(c)(3)-(d), will moot all pending stop loss exception litigation. Failure to make the repeal result in the application of DWC rule § 134.1(c)(3)-(d) would mean that the litigation will continue for years more, and then end in the same way – application of DWC rule § 134.1(c)(3)-(d).

After the DWC's decision not to appeal, the core of the pending litigation is about the validity of the 1997 fee rule's stop-loss exception assuming that exception only requires hospital charges exceeding $40,000. Repeal making DWC rule § 134.1(c)(3)-(d) control all fee disputes on pre-March 1, 2008 admissions moots that litigation.

If, however, Vista challenges the effectiveness of repeal to make DWC rule § 134.1(c)(3)-(d) control all fee

disputes on pre-March 1, 2008 admissions, and if Vista prevails, then it will be necessary for the courts to determine the validity of a rule that only requires that total audited charges exceed $40,000 and does not regulate charges. It will be at least 2009 and perhaps 2010 before the Third Court of Appeals issues its decision, and petitions for review by the Texas Supreme Court may postpone a final decision until 2011 and 2012.

Repeal specifying that DWC rule § 134.1(c)(3)-(d) controls will encourage SLX settlements – If the DWC specifies in repealing the 1997 hospital fee rule that DWC rule § 134.1(c)(3)-(d) controls fee disputes over pre-March 1, 2008 admissions, and moots the pending litigation over the 1997 fee rule's exception, this will encourage prompt settlements of what is "fair and reasonable" payment for such disputes, at or near the DWC's new Medicare-based fee rule fees.

This is the best hope the DWC has to encourage settlements of the more than 1,400 stop-loss exception fee disputes its data show as pending, at levels that the DWC's new Medicare-based fee rule indicates are fair and reasonable.

Request for Meeting With Commissioner Betts to Discuss ICT's Supplemental Comments

ICT would like to meet with Commissioner Betts to discuss the fore-going comments and related issues prior to the commissioner taking action on the proposed rule repeal.

Please contact me and let it know if it is possible to meet with Commissioner Betts and what date(s) and time(s) he has available to meet.

Respectfully,

Steven W. Nichols

Manager, Workers' Compensation Services

Insurance Council of Texas

Tel. No.: (512) 326-7618 or 444-9611

Fax. No.: (512) 444-0734

E-mail: snichols@insurancecouncil.org

APPENDIX 4

TAB 4

COPY

PRINGLE & GALLAGHER, L.L.P.
THE VAUGHN BUILDING
807 BRAZOS, SUITE 200
AUSTIN, TEXAS 78701
TELEPHONE (512) 472-8742
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PLEASE FILE STAMP AND RETURN

JOHN D. PRINGLE, P.C. *
* John D. Pringle - Board Certified - Administrative Law
Texas Board of Legal Specialization

LAURIE S. GALLAGHER, P.C.

March 24, 2008
Via Hand Delivery

The Honorable Albert Betts
Commissioner of Workers' Compensation
Texas Department of Insurance
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

Re: Division Proposed Repeal of existing Rule 134.401, Acute Care Inpatient Hospital Fee Guideline.

Dear Commissioner Betts:

Please allow this letter to serve as my written comments regarding the proposed repeal of existing Rule 134.401, the Acute Care Inpatient Hospital Fee Guideline, which was adopted in 1997. I make these written comments to the proposed repeal hoping you and the Division of Workers' Compensation will give them due consideration. The purpose of my written comments is to set out recommended changes to the proposed order of repeal. My recommended changes to the proposed order of repeal are to provide consistency and clarity in conjunction with other Division of Workers' Compensation rules.

As you know, Texas Government Code Section 2001.003 (6) (B) defines a "rule" as including "the amendment or repeal of a prior rule." Texas Government Code Section 2001.039 (d) provides that the procedures of the Government Code relating to the original adoption of a rule apply to the repeal of a rule. Those procedures are found in part in Texas Government Code Section 2001.033, State Agency Order Adopting Rule, which provides in part:

(a) A state agency order finally adopting a rule must include:

(1) a reasoned justification for the rule as adopted consisting solely of:

(A) a summary of comments received from parties interested in the rule that shows the names of interested groups or associations offering comment on the rule and whether they were for or against its adoption;

(B) a summary of the factual basis for the rule as adopted which demonstrates a rational connection between the factual basis for the rule and the rule as adopted; and

(C) the reasons why the agency disagrees with party submissions and proposals;

(2) a concise restatement of the particular statutory provisions under which the rule is adopted and of how the agency interprets the provisions as authorizing or requiring the rule; and

(3) a certification that the rule, as adopted, has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Please note that I support the repeal of current Rule 134.401. However, please take note that I disagree with the following statement found in the notice of the proposed repeal.

> Instead of per diem reimbursement, the stop-loss provision of §134.401(c) (6) provided for a reimbursement of 75% of total audited charges if those charges exceeded $40,000.

Heretofore it has been the Division of Workers' Compensation's position that the stop-loss method is to be used for "unusually costly services" as established in Rule 134.401(c)(6). The Texas Workers' Compensation Commission, the predecessor agency to the Division of Workers' Compensation, has in the past stated that in order "to determine if 'unusually costly services' were provided, the admission (or hospital stay) must: (1) not only exceed $40,000 in total audited charges, but (2) also involve 'unusually extensive services.'" Texas Workers' Compensation Commission Medical Dispute Resolution Newsletter Issue No: 5 Date: (April 2005).

The Division of Workers' Compensation should make it clear that it has abandoned or repudiated the foregoing position. In the alternative, the Division of Workers' Compensation should state in its reasoned justification for repeal of current Rule 134.401 that the foregoing position was a mistake or it was never the position of the agency and that the only requirement for stop-loss reimbursement for an inpatient admission was that after audit, the total audited charges exceeded $40,000.00.

In the notice of the proposed repeal, the Division of Workers' Compensation states the basis for said repeal:

> In 2001, the Legislature passed House Bill 2600, which amended Labor Code §413.011 by directing the Texas Workers' Compensation Commission to adopt a reimbursement structure modeled along the lines of the Medicare system.
>
> In accordance with that directive, the Division recently adopted §134.403, concerning Hospital Fee Guideline – Outpatient and §134.404, concerning Hospital Facility Fee Guideline – Inpatient, which will supersede the provisions of §134.401 on and after March 1, 2008. Section 134.403 and §134.404 implemented Labor Code §413.011 by adopting a standardized reimbursement

structure using in part the most current methodologies, models, values and weights used by the Centers for Medicare and Medicaid Services (CMS).

Section 134.401 no longer meets the needs of the workers compensation system. Since §134.401 will no longer be needed after March 1, 2008, the Division proposes the repeal of §134.401.

The Division of Workers' Compensation should make it clear that it had not adopted an inpatient hospital fee guideline in compliance with House Bill 2600 until 2008. In addition, the Division of Workers' Compensation should address how the pre-March 1, 2008, pending alleged stop-loss exception cases will be handled by the Division of Workers' Compensation. It is my opinion, that with the repeal of Rule 134.401, Division of Workers' Compensation Rule 134.1 will apply to the pending alleged stop-loss exception cases.

In addition, it is my understanding that the issue in the pending alleged stop-loss exception cases will be what it has always been, to wit: whether the health care provider is entitled to additional reimbursement. Another way of stating the issue is whether insurance carrier's reimbursement to the health care provider complied with the statutory standards found in Texas Labor Code Section 413.011. If the Division of Workers' Compensation disagrees with my opinions, then I would request the Division of Workers' Compensation state the basis and authority for its disagreement.

If you or the Division of Workers' Compensation Staff have any questions, comments or just wish to discuss my comments, please do not hesitate to contact me. Again, thank you for the opportunity to provide you and the Division of Workers' Compensation Staff with my comments to the proposed repeal of Rule 134.401.

By copy of this letter I am advising Victoria Ortega of this correspondence.

Very truly yours,

John D. Pringle

JDP/

Via Hand Delivery

cc: Victoria Ortega
Legal Services, MS-4D
Texas Department of Insurance,
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

f:\jdp\twcc\repeal ACIHFG ltr 3-24-08

APPENDIX 5

TAB 5

10-K 1 d10k.htm FORM 10-K FOR THE FISCAL YEAR ENDED AUGUST 31, 2009

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U.S. SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended August 31, 2009

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from _____ to _____

***Commission file number:* 000-21574**

DYNACQ HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Nevada	**76-0375477**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
10304 Interstate 10 East, Suite 369, Houston, Texas	**77029**
(Address of Principal Executive Offices)	**(Zip Code)**

Registrant's telephone number, including area code: (713) 378-2000

Securities registered pursuant to Section 12(b) of the Exchange Act: None

Securities registered pursuant to Section 12(g) of the Exchange Act:

Title of each class	Name of each exchange on which registered
Common Stock, $0.001 Par Value	NASDAQ

Indicate by check mark if the registrant is a well-known seasoned issuer as defined in Rule 405 of the Securities Act. Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. (Check One):

Large accelerated filer ☐ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) Yes ☐ No ☒

The aggregate market value of voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of February 28, 2009 was $19,814,277. As of November 9, 2009, the registrant had 15,236,279 shares of common stock outstanding.

Portions of the definitive proxy statement relating to the 2010 Annual Meeting of Shareholders of the Company, which will be filed with the Commission by December 28, 2009, are incorporated by reference in Items 10, 11, 12, 13 and 14 of Part III of this Form 10-K.

Table of Contents

The table below sets forth the percentage of our gross patient service revenue by financial class for the fiscal years 2009 and 2008:

	2009	2008
Workers' Compensation	48%	37%
Commercial	26%	41%
Medicare	11%	10%
Medicaid	— %	— %
Self-Pay	11%	10%
Other	4%	2%

Contractual Allowance

Starting March 1, 2008, the Company computes its contractual allowance based on the estimated collections on its gross billed charges. The Company computes its estimate by taking into account collections received, up to 30 days after the end of the period, for the services performed and also estimating amounts collectible for the services performed within the last six months. Prior to March 1, 2008, the contractual allowance was calculated based on the ratio of the Company's historical cash collections during the trailing twelve months on a case-by-case basis by operating facility. This ratio of cash collections to billed services was then applied to the gross billed services by operating facility. The following table shows gross revenues and contractual allowances for fiscal years 2009 and 2008:

	2009	2008
Gross billed charges	$134,379,125	$145,763,332
Contractual allowance	86,761,970	85,489,385
Net revenue	$ 47,617,155	$ 60,273,947
Contractual allowance percentage	65%	59%

A significant amount of our net revenue results from Texas workers' compensation claims, which are governed by the rules and regulations of the TDWC and the workers' compensation healthcare networks. If one of our hospitals chooses to participate in a network, the amount of revenue that will be generated from workers' compensation claims will be governed by the network contract.

For claims arising prior to the implementation of workers' compensation networks and out of network claims, inpatient and outpatient surgical services are either reimbursed pursuant to the Acute Care In-Patient Hospital Fee Guideline or at a "fair and reasonable" rate for services in which the fee guideline is not applicable. Starting March 1, 2008, the Texas Workers' Compensation 2008 Acute Care Hospital Outpatient and Inpatient Facility Fee Guidelines (the "Guidelines") became effective. Under these Guidelines, the reimbursement amounts are determined by applying the most recently adopted and effective Medicare reimbursement formula and factors; however, if the maximum allowable reimbursement for the procedure performed cannot be calculated using these Guidelines, then reimbursement is determined on a fair and reasonable basis.

Based on these new Guidelines, the reimbursement due the Company for workers' compensation cases is lower than we previously experienced. The Company has continued accepting Texas workers' compensation cases, and has not made any substantial changes in its focus towards such cases. Our net patient service revenue for Texas workers' compensation cases as a percentage of gross billing, has decreased primarily as a result of lower reimbursement rates for workers' compensation procedures still being performed.

Should our facility disagree with the amount of reimbursement provided by a third-party payer, we are required to pursue the MDR process at the TDWC to request proper reimbursement for services. From January 2007 to November 2008, the Company had been successful in its pursuit of collections regarding the stop-loss cases pending before the State Office of Administrative Hearings ("SOAH"), receiving positive rulings in over 90% of its claims presented for administrative determination. The 2007 district court decision upholding our interpretation of the statute as applied to the stop-loss claims was appealed by certain insurance carriers, and on November 13, 2008 the Third Court of Appeals determined that in order for a hospital to be reimbursed at 75% of its usual and customary

APPENDIX 6

TAB 6

STATE OFFICE OF ADMINISTRATIVE HEARINGS
300 West 15th Street, Suite 502
Austin, Texas 78701

DOCKET NO. 453-03-1233.M4
[MRD No. M4-02-4051-01]

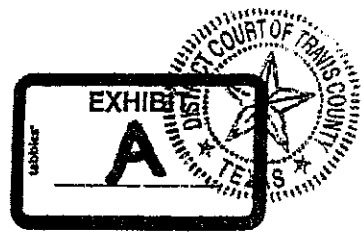
SAN ANTONIO INDEPENDENT SCHOOL DISTRICT, Petitioner	§	BEFORE THE STATE OFFICE
VS.	§	OF
TEXAS WORKERS' COMPENSATION COMMISSION AND METROPOLITAN METHODIST HOSPITAL, Respondents	§	ADMINISTRATIVE HEARINGS

DECISION AND ORDER

San Antonio Independent School District (SAISD) has appealed the Findings and Decision issued by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) in a fee dispute involving an interpretation of the Commission's hospital fee guidelines. The MRD determined that Methodist Metropolitan Hospital (Hospital) is entitled to total reimbursement of $55,508.51, using the Commission's stop-loss reimbursement methodology. Because SAISD had previously paid the Hospital $37,332.37, MRD ordered SAISD to reimburse the Hospital an additional $18,176.14. In response, SAISD argues that when appropriate reductions are made for surgical implantables and other audit adjustments, the correct total reimbursement amount is $24,911.05. Therefore, SAISD contends that it has already overpaid the Hospital and requests a refund of $12,421.32. The Administrative Law Judge (ALJ) finds the MRD properly applied the Commission's stop-loss methodology, denies SAISD's appeal, and finds that the Hospital is entitled to additional reimbursement of $16,472.32.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

On August 11, 2003, ALJ Thomas H. Walston convened a hearing on the merits at the SOAH hearing facilities in Austin, Texas. Attorney Dean G. Pappas represented SAISD and attorney Scott Placek represented the Hospital. The Commission did not participate in the hearing. Notice and jurisdiction were not contested and will be addressed in the findings of fact and conclusions of law. The hearing concluded and the record closed the same day.



II. DISCUSSION

A. Factual Overview

The basic facts were stipulated by the parties. On September 21, 1999, Claimant H.L. sustained a compensable injury. On June 20, 2001, Claimant was admitted to Metropolitan Methodist Hospital in San Antonio, where she underwent a laminectomy and decompressions with fusion at L3-4 and L4-5. Claimant was discharged from the Hospital on June 26, 2003. The Hospital submitted a bill to SAISD for $74,664.69 based on its usual and customary charges for the six-day inpatient stay and surgical procedure. The bill included $54,332.00 for surgical implantables and orthotic devices.

Pursuant to TWCC Rule 133.304(d), SAISD paid the Hospital $37,332.37, which equaled 50% of the Hospital's bill, pending an audit by Medical Audit Consultants, Inc. Ms. Deborah Wood, the Vice President of Medical Audit Consultants, then performed the audit. She added $106.72 for undercharges for pharmacy items, deducted $2,473.88 for charges not supported by documentation, and deducted $557.94 for charges unrelated to the compensable injury. In addition, Ms. Wood reduced charges for the surgical implantables from $54,332.00 to $15,797.14, which equaled the Hospital's cost plus 10%.[1] The following is a summary of Ms. Wood's adjustments:

Department	Hospital Bill Charges	Audited Under Charges (+)	Adjusted Hospital Bill (=)	Audited Unsupported Charges (-)	Audited Unrelated Charges (-)	UCR Credit Amount (-)	Audited Adjusted Charges (=)
Pharmacy	3,364.99	106.72	3,471.71	849.88	77.94	0.00	2,543.89
Central Supply	57,129.70	0.00	57,129.70	30.00	0.00	38,524.86	18,574.84[2]
Laboratory	1,829.00	0.00	1,829.00	233.00	480.00	0.00	1,116.00
Radiology	1,667.00	0.00	1,667.00	1,180.00	0.00	0.00	487.00
OR/Anesth/ RR	6,928.00	0.00	6,928.00	0.00	0.00	0.00	6,928.00
Physical Therapy	236.00	0.00	236.00	181.00	0.00	0.00	55.00
EKG/ECG/ EEG	150.00	0.00	150.00	0.00	0.00	0.00	150.00
Room & Care	3,360.00	0.00	3,360.00	0.00	0.00	0.00	3,360.00
Total	74,664.69	106.72	74,771.41	2,473.88	557.94	38,524.86	33,214.73

[1] The Hospital's cost was $14,361.04; cost plus 10% equals $15,797.14 ($14,361.04 x 1.10 = $15,797.14).

[2] Central Supply includes other items in addition to surgical implantables. Therefore, the total Central Supply amount is greater than the $15,797.14 allowed for the surgical implantables alone.

Ms. Wood then applied the stop-loss 75% reimbursement methodology to her audited balance of $33,214.73 to produce a total reimbursement amount of $24,911.05 [3] But because it previously paid the Hospital $37,332.37, SAISD contends that it is entitled to a refund of $12,421.32.

At hearing, the Hospital stated that it no longer disputes any of SAISD's audit adjustments except for the reduction of surgical implantables to cost-plus-10%. Addition of that reduction back into the audited bill produces a total audited bill of $71,739.59. Applying the TWCC stop-loss 75% reimbursement methodology to this amount produces a total reimbursement of $53,804.69.[4] Then, after deducting SAISD's prior payment of $37,332.37, the Hospital states that it is entitled to additional reimbursement of $16,472.32.[5]

In summary, the parties' positions are as follows:

	Hospital	SAISD
Total Bill	$74,664.69	$74,664.69
Audit Adjustments	(2,925.10)	(41,449.96)
Subtotal	71,739.59	33,214.73
75% Stop Loss Methodology	X 0.75	X 0.75
Reimbursement Amount	53,804.69	24,911.05
Less SAISD Payment	(37,332.37)	(37,332.37)
Balance Due / (Refund Due)	$16,472.32	($12,421.32)

[3] $33,214.73 x 0.75 = $24,911.05. SAISD recognizes that the stop-loss 75% reimbursement methodology is normally applied to audited balances of $40,000 or greater. However, it suggests that using this methodology actually benefits the Hospital because the Commission's per diem reimbursement methodology produces an even lower reimbursement amount. SAISD's witness calculated a per-diem reimbursement total of $22,511.14 (6 days x $1,118.00 per diem rate = $6,714.00 + $15,797.14 for implantables at cost-plus-10% = $22,511.14). This amount is slightly less than the $24,911.05 calculated by SAISD under the 75% stop-loss methodology.

[4] $71,739.59 x 0.75 = $53,804.69.

[5] This amount is $1,703.77 less than the $18,176.14 awarded by MRD. This result occurs because MRD reduced the Hospital's total bill by only $653.35 before applying the 75% reimbursement factor. But, as noted previously, the Hospital now agrees to the other audit reductions made by SAISD, except for the reduction for implantables. The agreed reductions total $2,925.10, which results in a lower reimbursement amount than MRD's award.

B. Parties' Arguments

1. Introduction

Under the Commission's Rules, when a hospital's total audited bill is less than $40,000, the hospital is reimbursed at a $1,118.00 per-diem rate for surgical admissions, plus certain itemized costs. These separate itemized costs include surgical implantables, reimbursed at the hospital's cost plus 10%. On the other hand, when a hospital's total audited bill is greater than $40,000, the Commission's stop-loss methodology 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."[6] The issue in this case is whether payment for surgical implantables at cost-plus-10% is part of the audit to determine if the $40,000 stop-loss threshold has been met, or whether it is only additional reimbursement under the per-diem reimbursement methodology.

2. SAISD's Arguments

SAISD contends that it properly calculated the Hospital's reimbursement and that the IRO's decision should be reversed. In essence, it argues that charges for surgical implantables must be set at cost-plus-10% regardless of whether the Commission's per-diem or stop-loss methodology applies. SAISD also contends that the Hospital handled the billing in this case consistent with SAISD's position. It points out that, as part of the billing in this case, the Hospital sent SAISD a separate invoice for implantables priced at cost-plus-10%, or $15,797.14, even though the Hospital originally billed these items at $54,332.00. Therefore, SAISD argues that it was justified in calculating the cost of the implantables at the lower price. After reducing the cost of implantables to cost-plus-10% and making other appropriate audit adjustments, SAISD paid 75% of the total audited charges. SAISD notes that under its approach, it technically should have reimbursed the Hospital based on a per-diem rate rather than on a stop-loss rate because the total audited charges were less than $40,000. However, SAISD states that its proposed reimbursement is actually greater than a per-diem reimbursement, so no harm results to the Hospital.

Ms. Debbie Wood testified for SAISD. She is the Vice-President of Medical Audit Consultants and she performed an audit on the Hospital's bill, as described previously. Ms. Wood discovered a small amount of undercharges for pharmacy, but she deducted other charges as either undocumented or unrelated to the compensable injury. In addition to the Hospital's original bill, Ms. Wood also received a separate invoice from the Hospital for surgical implants, such as cages, screws, and rods, listed at cost-plus-10%. She reduced the original bill for the implantables to cost-plus-10%, which, along with the other audit adjustment, reduced the Hospital's total bill from $74,664.69 to $33,214.73. Ms. Wood testified that she handled previous cases for the Hospital in the same manner, and SAISD offered into evidence invoices from five prior cases in which the Hospital submitted separate invoices that listed implantables at cost-plus-10%. Those invoices were submitted separately from the Hospital's original bill, which charged implantables at the ususal and

[6] 28 TEX. ADMIN. CODE (TAC) § 134.401(c)(6)

customary charge. After reducing the bill in this case to $33,214.73 for audit items and implantables, Ms. Wood then further reduced the bill by calculating reimbursement at 75% of this amount, or $24,911.05. Ms. Wood did not explain why she used the stop-loss methodology, as the audited bill under her calculation did not reach the $40,000 stop-loss threshold, except to say it was in accordance with Commission guidelines. Ms. Wood added, however, that her calculations using the stop-loss methodology provided the hospital a greater reimbursement than using the per-diem methodology.[7]

In summary, SAISD argues that it properly reimbursed surgical implantables at cost-plus-10%, that the MRD decision should be reversed, and that SAISD should recover a refund of $12,421.32.

3. Hospital's Arguments

The Hospital states that its total bill of $74,664.69 should only be reduced for personal items, unsupported charges, and unrelated charges in order to determine whether the "total audited charges" exceed the Commission's $40,000 stop-loss threshold. In this case, those adjustments total $2,925.10 and produce an audited balance of $71,739.59, which exceeds the stop-loss threshold.[8] Therefore, the Hospital contends that it is entitled to reimbursement of 75% of $71,739.59 (which equals $53,804.69), less $37,332.37 previously paid, for a current balance due of $16,472.32.

The Hospital argues that SAISD erroneously deducted implantable charges as part of the initial audit in order to reduce the "total audited charges" below the $40,000 stop-loss threshold. It states that the TWCC rules specify the deductions to be made to determine the audited charges for purposes of calculating the stop-loss threshold. These are personal items (such as telephone and television), undocumented services, and services not related to the compensable injury; but they do not include a deduction for surgical implantables.[9]

The Hospital notes that the general rule for hospital charges is set out in 28 TAC § 134.401(b)(2)(A), which provides:

> All hospitals shall bill their usual and customary charges. The basic reimbursement for acute care hospital inpatient services shall be the lesser of:
>
> (i) a rate negotiated for workers' compensation cases pre-negotiated between the carrier and hospital;
> (ii) the hospital's usual and customary charges; or
> (iii) reimbursement as set out in subsection (c) of this section for that admission.

---

[7] See footnote 3.

[8] 28 TEX. ADMIN. CODE § 134.401(c)(6).

[9] 28 TEX. ADMIN. CODE § 134.401(c)(6)(A)(v).

The Hospital states that it has no negotiated rate with SAISD and its usual and customary charges exceed the reimbursement methods under subsection (c) of § 134.401; consequently, its reimbursement in this case should be calculated under subsection (c) of the rule. The Hospital then notes that subsection (c) contains four independent reimbursement methodologies:

- the standard per-diem method [(c)(1)-(3)];
- additional reimbursements (that apply only to the per-diem methodology) for implantables, orthotics, prosthetics, MRIs, CAT scans, hyperbaric oxygen, blood, air ambulance, and pharmaceuticals charged at greater than $250 per dose [(c)(4)];
- a special methodology for trauma, burns, and HIV cases [(c)(5)]; and
- the stop-loss methodology for cases in which audited charges exceed the $40,000 stop-loss threshold [(c)(6)].

The Hospital complains that SAISD has erroneously used the cost-plus-10% *reimbursement methodology* for implantables in subsection (c)(4) as an *audit methodology* to determine whether the entire admission reaches the stop-loss threshold. It argues that the TWCC rules do not provide that the cost-plus-10% reimbursement methodology is a proper audit item. Instead, the Hospital emphasizes that § 134.401(c)(6)(A)(v) provides that the audit to calculate the stop-loss threshold should only examine hospital bills for usual and customary charges, personal items, undocumented services, and unrelated services. Then, the Hospital states, only after the audit has been completed can the carrier determine which reimbursement methodology to follow -- the per-diem methodology, with separate reimbursement for implantables, or the stop-loss methodology.

The Hospital also criticizes prior SOAH decisions which have concluded that a hospital's charges for implantables should be set at cost-plus-10% when calculating a hospital's audited charges for purposes of the stop-loss threshold.[10] In particular, the Hospital argues that those decisions failed to give proper weight to the Commission's own interpretation and application of the stop-loss rule. It points out that the Commission has interpreted the stop-loss rule consistent with the MRD's decision in favor of the Hospital in this case. The Hospital offered into evidence the Commission's "Question Resolution Log," which gives guidance to MRD employees for interpreting various Commission rules.

The Question Resolution Log states the following concerning implantables and calculating the stop-loss threshold:

[10] Docket No. 453-00-2092.M4 (April 24, 2001); Docket No. 453-01-1612.M4 (September 6, 2001); Docket No. 453-03-0910.M4 (April 10, 2003); Docket No. 453-03-1626.M4 (May 20, 2003).

DATE REC'D	QUESTION/PROBLEM	DATE ANS'D	RESOLUTION
10/12/00 01-03	STOP LOSS REIMBURSEMENT / RULE 134.401 / ACUTE CARE INPATIENT GUIDELINE / AUDIT / MEDICAL BILL How is the stop loss provision applied to the following situation? The hospital bill is $55,000. About $20,000 are charges for implantables. Is the bill reimbursed 75% of total bill per the stop loss method or is the charge for the implantables carved out to leave the remainder now under the stop-loss threshold and paid per diem?	10/17/00	According to the Acute Care Inpatient Fee Guideline 134.401(c)(6)(A) stop loss threshold is determined by total audited charges. An audit of the total bill allows for the deduction of charges such as personal items unrelated services and services not documented. Section (6)(A)(v) states what can be deducted by the carrier in the audit. The carrier should not confuse the carve-out items identified in section (c)(4) as items that can be deducted in an audit or paid separately. Therefore, reimbursement for the entire admission including charges for items in (c)(4) is calculated by the stop loss reimbursement amount of 75% times the total audited charges. In the instant case $55,000 x 75% = $41,250 reimbursement to the hospital.

The Hospital states that the Commission's interpretation of its own rules is entitled to great deference, and it argues that SOAH must accept the Commission's interpretation unless it is plainly erroneous. In the Hospital's view, the prior SOAH decisions failed to follow this fundamental rule of agency deference.

The Hospital also rejects the notion that hospitals can charge artificially inflated prices for implantables in order to push their bills above the stop-loss threshold. It points out that the Commission's rules require hospitals to bill their "usual and customary" charges and provide that all hospital charges are subject to audit.[11] Thus, if a carrier audit showed that a hospital's bill for implantables exceeded its usual and customary charges, the bill could be reduced accordingly. The hospital also offered testimony from Ms. Kimberly Brown, who handles billing for four Methodist Hospitals. She testified that the charges for implantables at issue in this case are its usual and customary charges and that the Hospital charges the same price for all patients, including private-pay patients and patients under Medicare or health insurance. Ms. Brown further testified that Workers' Compensation patients comprise only 4-5% of the Hospital's total patient load, and the Hospital does not set its charges for surgical implantables for the purpose of reaching the TWCC stop-loss threshold. Instead, Ms. Brown testified, the price markup on implantables is part of a comprehensive pricing analog for all hospital services, and the price markup is used to help defray hospital overhead expenses such as administration, collections, instrument sterilization, security, nursing costs, and other items. Further, she stated that competitive pressures from other hospitals prevent the Hospital

[11] 28 TAC § 134.401(b)(2)(A) (ususal and customary charges); 28 TAC 134.401(b)(2)(C) (audits)

from charging excessive prices.

The Hospital also argues that if audited charges for the stop-loss methodology included reducing implantables to cost-plus-10%, as argued by SAISD, then a hospital would not even be reimbursed its actual costs if the $40,000 threshold were met and the 75% reimbursement methodology applied. Under this scenario, the hospital would only be reimbursed 82.5% of its actual costs for implantables. This occurs because the price is marked up 10% for the audit, but then marked down 25% under the stop-loss reimbursement methodology.[12] Yet, the Hospital contends, the Commission adopted the guidelines to assure continued availability of care for injured workers, and the Commission did not intend that providers suffer out-of-pocket losses to treat injured workers.

In short, the Hospital argues that auditing hospital charges to determine whether the stop-loss 75% reimbursement methodology applies does not include reducing implantables to cost-plus-10%. Instead, the cost-plus-10% for implantables is simply an additional reimbursement that applies only to the per-diem reimbursement methodology. When the Hospital's charges in this case are properly audited, the Hospital contends that it is entitled to payment under the stop-loss-75% reimbursement methodology, which entitles it to an additional payment of $16,472.32.

III. ALJ's Analysis

The Commission's rules contain several basic principles that apply to this case. These include:

- All hospitals shall bill their usual and customary charges. (28 TAC § 134.401(b)(2)(A)).
- All charges submitted by hospitals are subject to audit as described in Commission rules. (28 TAC § 134.401(b)(2)(C)).
- A carrier's audit of a hospital bill may include examination for:
  (1) compliance with the fee guidelines established by the Commission;
  (2) compliance with the treatment guidelines established by the Commission;
  (3) duplicate billing;
  (4) upcoding and/or unbundling;
  (5) billing for treatments and services unrelated to the compensable injury;
  (6) billing for services not documented or substantiated, when documentation is required in accordance with Commission fee guidelines or rules in effect for the dates of service;
  (7) accuracy of coding in relation to the medical record and reports;
  (8) correct calculations; and/or
  (9) provision of unnecessary and/or unreasonable treatment(s) and/or services.

[12] For example, an implantable that cost a hospital $100 would be marked up 10% to $110 but then reimbursed at 75%, resulting in a reimbursement of $82.50 for an item with an actual cost of $100 ($100 x 1.10 = $110.00 x 75% = $82.50).

(28 TAC § 133 301(a)).

- The basic reimbursement for acute care hospital inpatient services is the lesser of:
(1) a rate for worker's compensation cases pre-negotiated between the carrier and the hospital;
(2) the hospital's usual and customary charges; or
(3) reimbursement as set out in subsection (c) of 28 TAC § 134.401.
(28 TAC § 134.401(b)(2)(A)).

- In this case, subsection (c) of 28 TAC § 134.401 is the lesser of the three options. That subsection provides for the following reimbursement methodologies:
(1) Standard per-diem amounts as follows: Medical— $870; Surgical—$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU)—$1,560. Reimbursement by per-diem rates applies unless an exception or special reimbursement provision controls. The surgical rate applies to this case.
(2) Special reimbursements in addition to the per diem rate, including surgical implantables and orthotics reimbursed at cost to the hospital plus 10%.
(3) Stop-loss reimbursement, as an exception to the standard per-diem amounts. Stop-loss reimbursement is 75% of the hospital's total "audited charges." For this methodology to apply, a hospital's total audited charges must exceed $40,000, the minimum stop-loss threshold. Stop-loss reimbursement is in lieu of and not in addition to per-diem and special reimbursement amounts.

- "Audited charges" for purposes of calculating the stop-loss threshold are those charges that remain after a bill review by the insurance carrier has been performed. Charges that may be deducted are for personal items (e.g., telephone, television). If an on-site audit is performed, charges for services that are not documented as rendered during the admission and services that are not related to the compensable injury may also be deducted. The formula to obtain audited charges for purposes of calculating the stop-loss threshold is: Total Charges - Deducted Charges = Audited Charges. (28 TAC § 134.401(c)(6)(A)(v)).

The issue in this case is whether the Hospital is entitled to reimbursement under the stop-loss methodology or under standard per-diem methodology, with additional payments for surgical implantables. Underlying this issue is the question of whether deductions from the Hospital's bill for calculating "audited charges" for purposes of the stop-loss threshold are limited to those deductions described in § 134.401(c)(6)(A)(v)—personal items, undocumented charges, and services unrelated to the compensable injury—or whether additional audit deductions can be made for other items listed in § 133.301(a). Initially, the Hospital argued that subsection (c)(6)(A)(v) is unambiguous and that audit deductions for calculating the stop-loss threshold are limited to personal items, undocumented charges, and unrelated charges. But in response to the argument that a Hospital could bill any amount it wanted, in order to inflate a bill, the Hospital agreed that a carrier could also make an audit deduction if a hospital billed in excess of its usual and customary charges. SAISD provided little evidence or argument on this question other than to state that it was entitled to reduce the billings for surgical implantables to the Hospital's cost plus 10%.

Prior SOAH decisions have concluded that the audit deductions for calculating the stop-loss threshold are not limited to the three items listed in subsection (c)(6)(A)(v) and may also include the items listed in § 133.301(a).[13] The ALJ agrees with those decisions and finds their reasoning to be sound. Section 134.401(b)(2)(C) provides, "*All charges* submitted by hospitals are subject to audit as described in Commission rules," and § 133.301 states that insurance carriers "*shall* retrospectively review all complete medical bills" and pay or deny the bills in accordance with the Worker' Compensation Act and the Commission's rules and fee guidelines. Clearly, the Commission recognizes that auditing is an important component in the worker's compensation system. Further, it is unreasonable to conclude that subsection (c)(6)(A)(v) would require a carrier to ignore hospital billing errors such as incorrect calculations, unreasonable or unnecessary treatments or services, upcoding, unbundling, duplicate billing, and the like. Even the Hospital has agreed that a Carrier could make additional audit reductions if a hospital failed to bill its usual and customary charges as required by Commission rules. Indeed, if under the stop-loss methodology carriers were limited to auditing only for the items listed in subsection (c)(6)(A)(v), then the carriers would have to reimburse hospitals for 75% of the billed charges regardless of whether treatment was delivered in accordance with the Act and Commission rules and regardless of how exorbitant the charges might be. Therefore, the ALJ concludes that when the Commission's rules are considered as a whole, it is clear that audit deductions for calculating the stop-loss threshold are not limited to the items listed in subsection (c)(6)(A)(v) and may include additional items listed in § 133.301(a).

However, the conclusion that a carrier's audit is not restricted to the items listed in subsection (c)(6)(A)(v) does not completely resolve the issue in this case. A further underlying question is whether reimbursement for surgical implantables at a hospital's cost-plus-10% is a proper audit item or is merely an additional reimbursement amount applicable to the per-diem methodology. 28 TAC § 134.401(b)(2)(B) provides:

> Additional reimbursements as outlined in subsection (c)(4) of this section are determined on a case-by-case basis within the guidelines established for the specific services rendered.

Then, subsection (c)(4) provides:

> (4) Additional Reimbursements. All items listed in this paragraph shall be reimbursed in addition to the normal per diem based reimbursement system in accordance with the guidelines established by this section. *Additional reimbursements apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.*
>
> (A) When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%:
>
> (i) Implantables (revenue codes 275, 276, and 278); and
>
> (ii) Orthotics and prosthetics
>
> (Emphasis added).

[13] See decisions cited in footnote 10.

The ALJ concludes that the subsection allowing additional reimbursement for implantables is only a part of the per-diem reimbursement methodology and is not a proper audit item to determine which methodology applies. First, the language in subsection (c)(4) states that additional reimbursement applies "only to bills that do not reach the stop-loss threshold." The ALJ believes that the Commission intended this provision to prevent a windfall to hospitals by making clear that hospitals are not entitled to both stop-loss reimbursement and additional reimbursement for implantables. In other words, if a hospital's audited bill exceeds $40,000 and the hospital qualifies for reimbursement under the stop-loss methodology, then the hospital is not entitled to additional reimbursement for implantables as it would be under the per-diem methodology.

But treating this cost-plus-10% reimbursement for implantables as an audit item causes an equally undesirable result of shortchanging hospitals by reimbursing them less than their actual cost. As noted previously, under the methodology proposed by SAISD and the prior SOAH decisions, a hospital would be reimbursed 110% of its actual cost for implantables under the per-diem methodology but only 82.5% of its cost for under the stop-loss methodology.[14] Thus, SAISD's interpretation produces a result that is the exact opposite of the statement in § 134.401(c)(6) that the stop-loss methodology was "established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." In other words, the ALJ finds that SAISD proposal is contrary to the Commission's rules because it reimburses hospitals at less than their actual costs for implantables, which is not "fair and reasonable compensation" as contemplated by the rule.

The ALJ also concludes that the Commission's interpretation of its rules in the Question Resolution Log is consistent with the Commission's rules. The Question Resolution Log is an internal document for use by MRD, and the ALJ is unclear about how much weight it should be given. Nevertheless, the ALJ finds that it does have some persuasive authority and supports the position urged by the Hospital in this case.

The prior SOAH decisions that adopted the position advocated by SAISD expressed serious concern about cost control and the high price markups for surgical implantables. The ALJ in this case is likewise concerned and notes that the Hospital marked up its price for the implantables at issue to 378% of cost.[15] However, SAISD, which has the burden of proof in this case, offered no evidence that the prices billed were not the Hospital's usual and customary charges (which the Hospital must bill under Commission rules), that the price markup was unreasonable, or that the final price was not fair and reasonable. In contrast, the Hospital offered testimony that the implantables were billed at the Hospital's usual and customary charge, that all patients are billed the same price for these items, and that the price markup is used to cover various overhead costs. Therefore, although the ALJ has concerns about the high price markup made by the Hospital, under the record in this case, the ALJ does not find that SAISD established that the prices charged by the Hospital were unreasonable or otherwise unlawful.

[14] See footnote 12 and accompanying text above.

[15] $54,332 / $14,361 = 3.783

In summary, the ALJ concludes that audit deductions for calculating the stop-loss threshold are not limited to the items listed in § 134.401(c)(6)(A)(v) and may include additional items listed in § 133.301(a); that a hospital's charges for surgical implantables should not be reduced to the hospital's cost-plus-10% when calculating whether the stop-loss threshold has been reached; and that SAISD did not establish by a preponderance of the evidence that the prices charged by the Hospital in this case for surgical implantables were unreasonable. Therefore, the ALJ denies SAISD's appeal an orders that SAISD pay $16,472.32 additional reimbursement to the Hospital.

IV. FINDINGS OF FACT

1. On September 21, 1999, H.L. sustained a compensable injury in the course and scope of her employment with the San Antonio Independent School District (SAISD).

2. On September 21, 1999, SAISD provided workers' compensation insurance through self-insurance.

3. SAISD contracts with Tristar Risk Management / EOS Claims Services for the administration of its workers' compensation insurance.

4. On dates of service June 20, 2001, through June 26, 2001, Metropolitan Methodist Hospital (Hospital) provided medical treatment to H.L. for her workers' compensation injury.

5. H.L. underwent a laminectomy and decompressions with fusion at the L3-4 and L4-5 levels.

6. SAISD preauthorized H.L.'s surgery.

7. H.L. was admitted to the Hospital on June 20, 2001, and discharged on June 26, 2001.

8. The Hospital submitted itemized billing totaling $74,664.69 for the services provided to H.L. for the dates of service June 20, 2001, through June 26, 2001.

9. SAISD reviewed the bills submitted by Hospital.

10. The Hospital's bill included charges totaling $54,332.00 for surgical implantables and orthotic devices used in the treatment of H.L. These charges were the Hospital's usual and customary charges for these items. The Hospital's actual cost for these items totaled $14,361.04.

11. SAISD did not perform an on-site audit of the bill but did perform a desk audit as allowed by law. Ms. Deborah Wood, Vice President of Medical Audit Consultants, performed the audit. In the audit, Ms. Wood added $106.72 for undercharges for pharmacy items, deducted $2,473.88 for charges not supported by documentation, and deducted $557.94 for charges unrelated to the compensable injury. Ms. Wood also reduced charges for surgical implantables and orthotic devices from $54,332.00 to $15,797.14, which equals the Hospital's cost plus 10%.

12. After making her audit adjustments, Ms. Wood calculated the Hospital's bill at $33,214.73, and she recommended reimbursement of 75% of that amount, which equals $24,911.05.

13. The Hospital does not dispute any of the audit changes made by Ms. Wood except for the reduction of charges for surgical implantables and orthotic devices.

14. On or about July 24, 2001, prior to the desk audit, SAISD issued a payment of $37,322.32 to Hospital for the services provided between June 20, 2001, and June 26, 2001.

15. Following completion of the desk audit on or about November 20, 2001, SAISD denied further reimbursement to the Hospital and requested recoupment in the amount of $12,421.32.

16. The Hospital requested Dispute Resolution Services from the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC) on June 7, 2002.

17. The MRD assigned Tracking Number M4-02-4501-01 to this dispute for dates of service June 20, 2001, through June 26, 2001.

18. SAISD filed a timely response with MRD on September 16, 2002.

19. On October 24, 2002, MRD issued its Findings and Decision, ordering SAISD to remit an additional $18,176.14 plus interest to the Hospital.

20. SAISD timely filed a request for a contested case hearing on the MRD's decision.

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

22. On August 11, 2003, ALJ Thomas H. Walston convened a hearing on the merits at the SOAH hearing facilities in Austin, Texas. Attorney Dean G. Pappas represented SAISD and attorney Scott Placek represented the Hospital. The Commission did not participate in the hearing. The hearing concluded and the record closed the same day.

23. The Hospital's total audited charges under § 134.401(c)(6)(A)(v) are $71,739.59, which allows the Hospital to obtain reimbursement under the Texas Workers' Compensation Commission's stop-loss reimbursement methodology.

24. Under the stop-loss methodology, the Hospital is entitled to total reimbursement of $53,804.69. After deduction of SAISD's prior payment of $37,332.37, the Hospital is entitled to additional reimbursement of $16,472.32.

V. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction to decide the issue presented, pursuant to TEX. LAB. CODE ANN. § 413.031.

2. 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.

3. SAISD timely filed notice of appeal, as specified in 28 TEX. ADMIN. CODE (TAC) §148.3.

4. Proper and timely notice of the hearing was provided to the parties according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5 SAISD had the burden of proof in this proceeding pursuant 28 TAC § 148.21(h) and (i).

6. As specified in 28 TAC § 134.401(c)(6), all inpatient services provided by an acute care hospital for a surgical admission will be reimbursed at 75% of total audited charges under the stop-loss methodology when the total audited charges exceed $40,000.

7. Applying the stop-loss methodology in this case, the Hospital is entitled to total reimbursement of $53,804.69.

8. As specified in Finding of Fact No. 14, SAISD has already reimbursed the Hospital $37,332.37.

9. Based on the foregoing findings of fact and conclusions of law, the SAISD owes the Hospital additional reimbursement of $16,472.32.

ORDER

It is hereby ORDERED that the San Antonio Independent School District shall reimburse the Metropolitan Methodist Hospital the additional sum of $16,472.32, plus interest, for services acute care hospital services rendered to H.L. between June 20 and June 26, 2001.

SIGNED October 9, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

Thomas H. Walston

THOMAS H. WALSTON
ADMINISTRATIVE LAW JUDGE

APPENDIX 7

TAB 7

SOAH DOCKET NO. 453-04-4223.M4
TWCC MR NO. M4-03-0775-01

AMERICAN HOME ASSURANCE COMPANY, Petitioner	§	BEFORE THE STATE OFFICE
V.	§	OF
BAYLOR UNIVERSITY MEDICAL CENTER, Respondent	§	ADMINISTRATIVE HEARINGS

DECISION AND ORDER

This is a dispute over interpretation of the stop-loss provisions of the Texas Workers' Compensation Commission's (the Commission's) 1997 Acute Care Inpatient Hospital Fee Guideline. The Administrative Law Judge (ALJ) concludes the stop-loss provisions apply and that the workers' compensation carrier should reimburse the hospital an additional $11,600.70, as ordered by the Commission's Medical Review Division, plus interest.

I. HISTORY AND ISSUES

On October 22, 2001, the workers' compensation claimant (Claimant) underwent spinal fusion surgery at Baylor University Medical Center (BUMC). The Claimant remained in the hospital through October 25, 2001. BUMC calculated the bill for its services at $40,375.18, and requested reimbursement of 75 percent of that amount, which is $30,281.39. The 75 percent figure was based on the stop-loss provisions of the Commission's 1997 Acute Care Inpatient Fee Guideline (the Guideline), 28 TEX. ADMIN. CODE (TAC) §134.401(c)(6). Under the Guideline, hospital stays typically are reimbursed at a *per diem* rate. As explained in that subsection of the Guideline, however,

> Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. This methodology shall be used in place of and not in addition to the per diem based reimbursement system . . . .

The minimum level for application of the stop-loss methodology--the stop-loss threshold--is $40,000. If a bill qualifies for the stop-loss methodology, reimbursement for the entire admission is paid at 75 percent of the audited charges.

In this case, BUMC's bill included a charge of $22,691.47 for implantables,[1] which was its usual and customary charge of cost plus 68 percent. In its audit, the workers' compensation carrier, American Home Assurance Company (AHAC), reduced the pricing for the implantables to cost plus ten percent, which it claims is the fair and reasonable level mandated by the Guideline. That reduction brought the total bill below the stop-loss threshold of $40,000. Therefore, AHAC paid the *per diem* amounts, plus the cost of the implantables plus ten percent and other minor items. The difference between that amount and what BUMC believes is appropriate reimbursement is $11,600.70.

After its request for reconsideration was denied, BUMC filed a timely request for medical dispute resolution. The Commission's Medical Review Division ruled in BUMC's favor, whereupon AHAC filed a timely request for a hearing.

The hearing was convened June 14, 2004, with ALJ Henry D. Card presiding. Both AHAC and BUMC appeared at the hearing, which was adjourned the same day. The record closed June 30, 2004, with the filing of AHAC's responsive written argument.

[1] Implantables are hardware, *e.g.* screws and rods, implanted in a patient during back fusion surgery.

AHAC argues that it was entitled, and indeed required, to audit BUMC's bill under the Guideline itself, 28 TAC §134.401(b)((2)(C) and the Commission's rule for retrospective review of medical bills, 28 TAC §133.301. In its audit, AHAC determined that the fair and reasonable charge for implantables was cost plus ten percent.[2] Reducing the implantables to that level brought the bill below the stop-loss threshold.

AHAC further argues that even if the bill were properly over $40,000, BUMC still has to prove that the fusion procedure was "unusually costly" or "unusually extensive" as set out in the stop-loss portion of the Guideline itself, 28 TAC §134.401(c)(6). It provided testimony that this was a typical, rather than an unusual, back fusion surgery.

AHAC cited three previous SOAH cases that have dealt with these issues.[3] All three were decided in favor of the carriers.

BUMC contends that it is entitled, and indeed required, to bill its "usual and customary charges" under 28 TAC §134.401(b)(2)(A). Its charge for implantables was its usual and customary charge. BUMC argues that the scope of a carrier audit of a stop-loss claim, as set forth in the stop-loss methodology, is limited to deducting for personal items (*e.g.* telephone, television) and items not related to the compensable injury. See 28 TAC §134.401(c)(6)(A)(v).

Even if a more extensive audit were appropriate, BUMC claims its charges were fair and reasonable. It presented evidence showing its mark-up on implantables to be below that of other

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[2] In its Explanation of Benefits (EOB), AHAC encoded the reason for its reduction as "M - Reduced to fair and reasonable." "M" is one of the codes established by the Commission for use on EOB forms, also known as "TWCC 62s." That code is for reductions on treatments and services for which the Commission has not established a maximum allowable reimbursement (MAR).

[3] Docket No. 453-00-2092.M4 (April 24, 2001); Docket No. 453-01-1612.M4 (September 6, 2001); and Docket No. 453-03-0910.M4 (April 10, 2003). *See also* Docket No. 453-03-1626.M4 (May 20, 2003). However, the opposite conclusion was reached in Docket No. 453-03-1233.M4 (October 9, 2003).

comparable providers. It further presented evidence that the average managed care payer reimburses implantables at 80 percent of billed charges, which is considerably above the cost plus ten percent used by AHAC as its "fair and reasonable" standard.

BUMC contends there is not a separate requirement that a provider show the services rendered were unusually costly or extensive. According to BUMC, services by definition are unusually costly or extensive if they meet the $40,000 stop-loss threshold.

II. ALJ'S ANALYSIS

Under 28 TAC §148.21(h), the Petitioner, in this case AHAC, has the burden of proof. The ALJ concludes it did not meet that burden.

The first issue is the extent to which AHAC could audit the bill. The ALJ agrees with AHAC, and with the earlier SOAH decisions, that AHAC was entitled to review the bill retrospectively under the provisions of 28 TAC §133.301. Despite the language of 28 TAC §134.401(c)(6), the audit was not limited to the deduction of personal items and items unrelated to the compensable injury. Both 28 TAC §134.401(b)(1)(C) and 28 TAC §133.301 authorize and require a more extensive audit. The statutory scheme and common sense require a more extensive audit as well. If the audit were limited to the issues set out in 28 TAC §134.401(c)(6)(A)(v), a carrier would not be allowed to consider such basic problems as duplicate billing or inaccurate mathematical calculations, which are elements of the auditing rule. Nor could it consider whether a provider had billed far above its usual and customary charges.[4]

The second issue is whether, in the audit, AHAC properly reduced the implantables charge to the "fair and reasonable" level of cost plus ten percent. The Guideline, at 28 TAC

[4] The ALJ is not suggesting BUMC has, or would, do so.

§134.401(c)(4)(A)(i), establishes cost plus ten percent as the level of reimbursement for implantables. The preamble to the rule discusses the fairness and reasonableness of that level. As BUMC points out, however, that subsection of the rule only establishes the level of additional reimbursements, supplementing the *per diem* rates, when total charges fall below the stop-loss threshold. Section 134.401(c)(4) specifically states:

> Additional reimbursements apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

Moreover, the preamble to the rule observes,

> In the case of pharmaceutical carve outs and carve outs identified by revenue codes, the whole bill is paid according to stop-loss provision if the stop-loss threshold is reached.

22 Tex Reg. at 6279, 6288 (July 4, 1997)

Implantables are one of the carve outs identified by revenue codes to which that sentence refers. From the Guideline itself and the preamble, it is clear that the Guideline does not set a reimbursement rate for implantables for all purposes.

As was pointed out in Docket No. 453-03-1233.M4, the use of cost plus ten percent, combined with application of the stop-loss factor, would actually reduce reimbursement for implantables below their cost. If, for example, the implantables cost $1,000, the purported "fair and reasonable reimbursement level would be $1,100. The hospital would actually be reimbursed 75 percent of that amount, or $825.[5]

[5] That problem would not occur if implantables were always carved outs and paid at 110 percent, regardless of whether the stop-loss threshold were met. In the ALJ's view, that is not the treatment envisioned by the Guideline.

In 28 TAC §134.401(b)(2), the Guideline instructs hospitals how to bill and sets the basic parameters for reimbursement:

> (A) All hospitals shall bill their usual and customary charges. The basic reimbursement for acute care hospital inpatient services shall be the lesser of:
>
> (i) a rate for workers' compensation cases pre-negotiated between the carrier and hospital;
> (ii) the hospital's usual and customary charges; or
> (iii) reimbursement as set out in subsection (c) of this section for that admission.

In this case, there is no pre-negotiated rate. Nor is there a specific rate set out in subsection (c) for implantables, except in the context of additional reimbursement to supplement the *per diem* levels. The Guideline does not set a general implantables rate to be used in the auditing process.

Nor does 28 TAC §133.301, contain a provision that allows carriers generally to reduce rates to "fair and reasonable" levels. Instead, the Guideline states that BUMC is to bill its usual and customary rate. AHAC may audit the bill to ensure that rate was charged, but may not impose its own "fair and reasonable" rate. BUMC proved, however, that it had billed its usual and customary charges.

The third issue is whether BUMC must prove this surgery was unusually costly or unusually extensive, beyond showing that it met the stop-loss monetary threshold. AHAC argues that the stop-loss provisions of the rule require that additional element of proof. The Guideline, at 28 TAC §134.401(c)(6) states, in pertinent part,

(6) Stop-Loss Method. Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.

* * * *

(A)(ii) This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.

The ALJ disagrees. He interprets the language in the Guideline as explaining the purpose of the stop-loss provisions. Nothing in those sections directs a hospital to provide additional information concerning the relative cost or extensiveness of admissions in order to qualify for stop-loss. Nor does the preamble suggest any such requirement. The ALJ concludes that an admission meets the stop-loss criteria if the properly audited charges for that admission exceed $40,000. A hospital need not show that the procedure was otherwise unusually costly or extensive.

AHAC argues that basing reimbursement on the hospitals' usual and customary charges would defeat the cost-control objectives of the Labor Code and the Commission's rules. It cited examples of charges for implantables well above those billed by BUMC in this case.[6] The ALJ appreciates that argument. However, the Commission considered its cost-control responsibilities in promulgating the Guideline. It is for the Commission, not SOAH, to determine how to meet those objectives.

The ALJ concludes the stop-loss provisions of 28 TAC §134.401 should be applied in this case, as determined by the Medical Review Division. Therefore, AHAC should reimburse BUMC an additional $11,600.70, plus interest.

[6] BUMC provided similar information to support the reasonableness of its own charges.

III. FINDINGS OF FACT

1. On October 22, 2001, the workers' compensation claimant (Claimant) underwent spinal fusion surgery at Baylor University Medical Center (BUMC).

2. The Claimant remained in the hospital through October 25, 2001.

3. BUMC calculated the bill for its services at $40,375.18, and requested reimbursement of 75 percent of that amount, which is $30,281.39.

4. The 75 percent figure was based on the stop-loss provisions of the Commission's 1997 Acute Care Inpatient Fee Guideline (the Guideline), 28 TEX. ADMIN. CODE (TAC) §134.401(c)(6).

5. BUMC's bill included a charge of $22,691.47 for implantables, which was its usual and customary charge of cost plus 68 percent.

6. BUMC's usual and customary charges for the services rendered the Claimant were $40,375.18.

7. In its audit, the workers' compensation carrier, American Home Assurance Company (AHAC), reduced the pricing for the implantables to cost plus ten percent.

8. AHAC's reduction brought the total bill below the stop-loss threshold of $40,000.

9. Because the audited total bill was below $40,000, AHAC paid the *per diem* amounts set out in the Guideline, plus the cost of the implantables plus ten percent and other minor items.

10. The difference between the amount paid by AHAC and the amount that would be payable under the stop-loss methodology is $11,600.70.

11. After its request for reconsideration was denied, BUMC filed a timely request for medical dispute resolution.

12. The Commission's Medical Review Division ruled in BUMC's favor, whereupon AHAC filed a timely request for a hearing.

13. Notice of the hearing was sent to all parties March 31, 2004.

14. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to

the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

15. The hearing was convened June 14, 2004, with ALJ Henry D. Card presiding. Both AHAC and BUMC appeared at the hearing, which was adjourned the same day.

16. The record closed June 30, 2004, with the filing of AHAC's responsive written argument.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §2001.052.

3. Under 28 TAC §148.21(h), the Petitioner, in this case AHAC, has the burden of proof.

4. Under the Guideline, hospital stays typically are reimbursed at a *per diem* rate.

5. The stop-loss provisions of the Guideline, 28 TEX. ADMIN. CODE (TAC) §134.401(c)(6), establish an independent reimbursement methodology in lieu of the *per diem* methodology.

6. AHAC was entitled to review BUMC's bill retrospectively under the provisions of 28 TAC §133.301.

7. Pursuant to 28 TAC §134.401(b)(1)(C) and 28 TAC §133.301, AHAC's audit was not limited to the deduction of personal items and items unrelated to the compensable injury.

8. The Guideline, at 28 TAC §134.401(c)(4)(A)(i), establishes cost plus ten percent as the level of reimbursement for implantables only when the implantables are additional reimbursements, supplementing the *per diem* rates, when total charges fall below the stop-loss threshold.

9. The Guideline does not set a reimbursement rate for implantables for all purposes.

10. The Guideline does not set a general implantables rate to be used in the auditing process.

11. The Guideline, at 28 TAC §134.401(b)(2), instructs hospitals to bill their usual and customary charges.

12. Under 28 TAC §133.301, a carrier may audit bills submitted under the stop-loss provisions of the Guideline to ensure that hospitals billed their usual and customary charges.

13. Under 28 TAC §133.301, carriers may not impose their own "fair and reasonable" rate for implantables.

14. Under 28 TAC §134.401(c)(6), hospitals do not need to show that surgery was otherwise unusually costly or unusually extensive, beyond showing that the properly audited charges met the stop-loss monetary threshold.

15. The stop-loss provisions of 28 TAC §134.401 should be applied in this case.

16. AHAC should reimburse BUMC an additional $11,600.70, plus interest.

SIGNED August 19, 2004.

HENRY D. CARD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX 8

TAB 8

SOAH DOCKET NO. 453-04-3600.M4
TWCC MRD NO. M4-03-0785-01

DILLARDS DEPARTMENT STORES, SELF-INSURED, Petitioner	§	BEFORE THE STATE OFFICE
V.	§	OF
HUGULEY MEMORIAL HOSPITAL, Respondent	§	ADMINISTRATIVE HEARINGS

DECISION AND ORDER

Dillards Department Stores, a self-insured entity (Carrier), challenged the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) awarding additional reimbursement to Huguley Memorial Hospital (Hospital) for costs billed for the hospitalization of ___ (Claimant) for a spine surgery. The MRD concluded that Hospital was entitled to additional payment as it qualified for payment under the stop-loss reimbursement method provided for in 28 TEX. ADMIN. CODE § 134.401, the Acute Care Inpatient Hospital Fee Guideline (HFG or Rule 134.401). Carrier had reimbursed Hospital under the per diem method.

Based on the evidence, Carrier failed to meet its burden of proof to show it had authority to use the per diem method to reimburse Hospital for Claimant's stay.[1] Carrier must pay Hospital additional reimbursement in the amount of $57,045.48, the difference between the amount it paid and the amount Hospital is entitled to be paid under the stop-loss computation set forth in Rule 134.401(c)(6)(B).

The hearing in this matter convened on August 25, 2004, in Austin, Texas, with Administrative Law Judge (ALJ) Cassandra Church presiding. The record closed on September 3, 2004, the date parties filed closing argument. Hospital was represented by Phillip E. Cannatti, attorney. Carrier was represented by Jack W. Latson, attorney. The Commission did not participate in the hearing.

Matters of jurisdiction and notice were not disputed, so are set forth in the Findings of Fact and Conclusions of Law without further discussion here.

I. DISCUSSION

1. Background

Claimant, Carrier's employee, was admitted to the Hospital on October 23, 2001, as a surgical patient. Claimant was admitted for performance of spinal stabilization and fusion on several lower spine levels. These procedures included instrumentation. Hospital supplied the surgeon with

[1] At the contested case hearing, the ALJ assigned the burden of proof to Carrier as it was the party seeking relief from an adverse decision of the MRD. TEX. LAB. CODE ANN. § 413.031, 28 TEX. ADMIN. CODE §§ 148.21(h).

the devices installed in Claimant's body, *i.e.*, a rod, screws, two stabilization cages or meshes, and bone material. Hospital billed Carrier directly for these devices in the amount of $69,743.80.

Claimant was discharged on October 29, 2001. Hospital's total charge for Claimant's six-day stay was $94,689.05, for which it sought reimbursement from Carrier under the stop-loss method. That method provides that hospital bills over $40,000, after audit, shall be reimbursed at 75 percent of audited charges.[2] Carrier did not perform an on-site audit of the bill, but did conduct a bill review. In that review, Carrier concluded Hospital should be reimbursed using the per diem method because it determined that the services were not unusually costly or extensive, or the stay unusually lengthy, within the meaning of Rule 134.401(c)(6)(B). Carrier also concluded that Hospital's bill, as recalculated by Carrier, was under $40,000. Carrier arrived at this figure by recalculating the value of Hospital's implantable charges at cost plus 10 percent. Cost plus 10 percent is the amount authorized under the per diem method to reimburse hospitals for certain qualifying items. Implantables are an item qualifying for additional reimbursement above and beyond the Hospital's daily charges under the per diem method.[3] Hospital's acquisition cost of the implantables was $6,603. The cost plus 10 percent amount was thus recalculated by Carrier to be $7,263.30.[4]

After Carrier recalculated the price of the implantables, Carrier also recalculated the cost of the per-day charges for a six-day surgical stay by applying the $1,118 daily rate provided for under the per diem method. Carrier then added the recalculated daily rate, $6,708.00, and the implantable amount, $7,263.30, to arrive at the reimbursement amount of $13,971.30, which it paid Hospital. Carrier denied the remainder of the claim as being contrary to the HFG.

Hospital appealed Carrier's partial denial to the MRD. On February 2, 2004, the MRD determined that charges arising out of Claimant's hospitalization were entitled to be reimbursed under the stop-loss method. The MRD ordered Carrier to reimburse Hospital the additional amount of $57,045.58, the difference between what it paid and what would have been due under the stop-loss method.[5] The MRD also held that Carrier could not "carve out" implantables and re-price them in
order to make its decision on the applicability of the stop-loss method. The MRD also held that the Hospital had billed its usual and customary charges. On February 4, 2004, Carrier requested a contested case for reconsideration of the MRD decision.

2. Summary of Issues

The first issue presented by this case was the legal issue of whether Hospital's charges were sufficient to trigger the application of the stop-loss method of reimbursement or whether it also had

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[2] 28 TEX. ADMIN. CODE § 134.401(c)(6) (A) - (C).

[3] 28 TEX. ADMIN. CODE § 134.401(c)(4). Other qualifying items include orthotics and prosthetics.

[4] Carrier Exh. 4.

[5] As Carrier did not audit Hospital's bill for any reason other than qualification for stop-loss, Carrier did not reduce Hospital's bill on any other grounds. Thus, in this case, the Hospital's initial bill was the "audited charges." The MRD applied the stop-loss formula, multiplying the $94,689 05 (audited charges) x 75 percent (stop-loss reimbursement factor) ' $71,016.78 (workers' compensation reimbursement amount). As Carrier had already paid Hospital $13,971 30, the MRD ordered Carrier to pay Hospital the difference between those two figures, $57,045.48, plus accrued interest.

to demonstrate additional elements concerning the nature of the care provided in order to qualify for reimbursement under this method. The second issue presented is whether Carrier had the authority to carve out and recalculate the cost of implantables in order to arrive at the amount of audited charges in aid of determining whether Hospital qualified for reimbursement under the stop-loss method.[6]

The parties agreed that a hospital must charge its usual and customary fees in order to qualify for reimbursement.

3. Parties' Positions

Carrier argued that there are two criteria a hospital must meet in order to qualify for reimbursement using the stop-loss method and that Hospital had met neither. First, a hospital must demonstrate that the stay involved procedures or services that were unusually extensive[7] or unusually costly.[8] Second, a hospital must submit a bill showing charges, after audit, of over $40,000, exclusive of items classified by the HFG as "additional items." Carrier argued that considering the dollar amount as the only triggering factor ignores other principles in the Commission's overall health care reimbursement scheme, *i.e.*, containing medical costs and avoiding a grant of unchecked authority to providers to charge prices unrelated to the actual cost of providing care.[9] Carrier argued that in this case, Hospital had failed to demonstrate that the procedures performed or services provided were either unusually costly or unusually extensive, or the stay lengthy, thereby failing to qualify for stop-loss reimbursement on substantive grounds. It also argued that Hospital's bill did not meet the dollar threshold after implantables were deducted and recalculated.[10] Carrier argued there was a presumption in favor of per diem compensation.

Carrier also argued that the general grant of authority to carriers to conduct bill reviews permitted its practice of assessing the nature of the services and also of recalculating implantable costs before determining whether a bill qualified for stop-loss reimbursement. Carrier did not dispute the fact that the HFG does not expressly provide for either step in conducting a bill review. Notwithstanding that, Carrier argued its practices were consistent with the provisions in the Texas Labor Code requiring provision of appropriate care at reasonable costs. Carrier argued that such a requirement should be inferred from a broad reading of Rule 134.401 in concert with the Labor Code. It argued that to find otherwise would result in a rule that exceeded the mandate in the Labor Code to provide for reasonably-priced health care for injured workers.

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[6] 28 TEX. ADMIN. CODE § 134.401(c)(6)(A)(v).

[7] 28 TEX. ADMIN. CODE § 134.401(c)(6)(A)(ii).

[8] 28 TEX. ADMIN. CODE § 134.401(b)(1)(F) and (c)(6).

[9] The Texas Workers' Compensation Act (the Act) has several objectives in addition to controlling costs, including providing compensation for health care providers that is fair and reasonable and ensuring quality of medical care for injured Texas workers. TEX. LAB. CODE ANN. § 413.011 (d) - (g).

[10] Carrier took the position that it should be able to reimburse implantables at cost plus 10 percent even if the services were sufficiently costly or extensive to merit stop-loss reimbursement. It argued further that it should be the *remainder* of the billBminus the implantables or other qualifying additional itemsBthat would determine whether a hospital met the $40,000 threshold.

For its part, Hospital argued that there are only two factors relevant to determining whether the stop-loss method applies and that it met both of them. The first factor is the total amount of the bill which must exceed the threshold amount of $40,000, after audit. The second is whether the hospital charged its usual and customary charges. Hospital argued since its bill was over the $40,000 threshold and Carrier had not reduced that bill by any allowable audit deductions, and since its charges were its usual and customary rates, it should have been reimbursed using the stop-loss formula. Hospital asserted that Rule 134.401 does not require a hospital to demonstrate additional facts about the nature of the admission or procedures in order to qualify for stop-loss payment. Hospital also disputed that the rule contains a presumption in favor of per diem compensation.

In addition, Hospital asserted that the Commission's bill-auditing rules do not authorize a carrier to recalculate the cost for implantables using the cost plus 10 percent method before it makes a decision on whether a hospital's bill has reached the stop-loss threshold. Hospital argued that Carrier's only valid grounds for avoiding payment under the stop-loss method in this case would have been to demonstrate that Hospital's charges for the implantables were not its usual and customary charges and that Carrier had failed to do so.[11]

Hospital also argued that in fee disputes on this issue, the Commission has consistently barred carriers from "carving out" implantables when determining whether the stop-loss alternative should be applied. Hospital argued the agency's interpretation of this rule is entitled to deference.

4. Applicable Authority

The HFG sets forth the step-by-step procedures for submitting and paying hospital bills for injured workers.[12] For the most part, it outlines the procedures to be used by providers and carriers for filing for and paying reimbursement. However, the passages of Rule 134.401 pertaining to the stop-loss method contain both objectives and procedures.

The steps for this reimbursement method are as follows:

- Stop-loss is an independent methodology established to ensure fair and reasonable compensation to the hospital for an unusually costly or lengthy hospital stay.[10]
- Stop-loss is to be used in place of and not in addition to the per diem based reimbursement system.[11]
- The stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.[12]

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[11] 28 TEX. ADMIN. CODE § 134.401(b)(2).

[12] 28 TEX. ADMIN. CODE § 134.401

[10] 28 TEX. ADMIN. CODE §§ 134.401(b)(1)(F) - (H) and (c)(6).

[11] 28 TEX. ADMIN. CODE § 134.401(c)(6).

[12] 28 TEX. ADMIN. CODE § 134.401(c)(6)(A)(ii). There is yet a third category of reimbursement created for hospital care for patients with specified diagnoses, *i.e.*, trauma, burns, and human immunodeficiency virus. 28 TEX.

The mechanics for applying this reimbursement method are as follows:

- Submission of a bill containing audited charges in excess of $40,000.[13]
- Determination that the charges are the hospital's "usual and customary charge."[14]

The steps for arriving at the audited charges are as follows:

- Carrier may deduct personal items, line items for services not rendered, and charges unrelated to the compensable injury.[15]
- Carrier may deduct items which would be subject to audit as described in Commission rules, specifically 28 TEX. ADMIN. CODE 133.301(a) which provides for review for unbundling, services unrelated to the injury, and the like.[16]

E. Discussion

1. Qualification for Stop-Loss Reimbursement

In arguing for a two-step qualification process, Carrier relied on its reading of the Labor Code and evidence regarding the Commission's intent in adopting Rule 134.401. As noted above, Carrier
argued that a rule which appears to provide no cost containment checks and balances is contrary to the tenets of the Labor Code.[17] In addition to its legal arguments, Carrier offered the testimony of Julie Shank, R.N. Ms. Shank worked for the Commission at the time the HFG and other fee guidelines were being written and assisted in researching and drafting these guidelines. Since

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ADMIN. CODE § 134.401(c)(5). Those costs are reimbursed at "a fair and reasonable rate." 28 TEX. ADMIN. CODE § 134.401(c)(6).

[13] 28 TEX. ADMIN. CODE § 134.401(c)(6)(A)(i)

[14] 28 TEX. ADMIN. CODE § 134.401(b)(2)(A).

[15] 28 TEX. ADMIN. CODE § 134.401(c)(6)(A)(v).

[16] 28 TEX. ADMIN. CODE § 134.401(b)(2)(C) Under Rule 133.301(a), a carrier's audit of a hospital bill may include examination for:

(1) compliance with the fee guidelines established by the Commission;
(2) compliance with the treatment guidelines established by the Commission;
(3) duplicate billing;
(4) upcoding and/or unbundling;
(5) billing for treatments and services unrelated to the compensable injury;
(6) billing for services not documented or substantiated, when documentation is required in accordance with Commission fee guidelines or rules in effect for the dates of service;
(7) accuracy of coding in relation to the medical record and reports;
(8) correct calculations; and/or
(9) provision of unnecessary and/or unreasonable treatment(s) and/or services.

[17] *Compare* SOAH Docket Nos. 453-03-0910.M4 (April 2003, Sullivan), 453-01-1612.M4 (September 2001, Cunningham), and 453-00-2092.M4 (April 2001, Cunningham)

leaving the Commission, she has been employed as consultant on medical benefit issues. She reviewed Hospital's bill for stop-loss qualification but did not audit the bill for other errors.

Ms. Shank testified that it was her belief that the intent of the Commission was to treat potential stop-loss cases like hospital stays for catastrophic injuries. She contended that it was the Commission's intention that in order to qualify for the more-generous compensation levels of the stop-loss method, hospitals would have to demonstrate a medical basis for why a hospital stay not in one of the defined catastrophic categories warranted stop-loss treatment. The stop-loss provisions in the workers' compensation system were modeled on stop-loss provisions in insurance contracts with other types of payors.

Carrier also offered the testimony of Michael M. Albrecht, M.D., an orthopedic surgeon. After reviewing the records, Dr. Albrecht concluded Claimant's treatment and recovery were not out of the ordinary for a patient with the condition she presented.

For its part, Hospital relied primarily on the plain language of the HFG, arguing that Carrier provided no justification for reading additional requirements into Rule 134.401. Hospital argued that restrictions could have been put in the HFG but that they were not. Hospital also argued that the rule does not contain any preference for the per diem method.

Carrier's argument that this rule tips the balance too far away from cost containment may carry considerable weight in another forum, but it lacks merit here. Carrier is asking the ALJ to substitute her interpretation of the purpose and objectives of Rule 134.401 for that of the Commission without demonstrating there is any conflict between the rule and a provision in the Labor Code or even any ambiguity in the language of the rule itself.[18] The detailed preamble to the HFG discusses the Commission's efforts to achieve a balance among the many conflicting objectives of the Act.[19] Those efforts resulted in the language in Rule 134.401. Given the straightforward language in Rule 134.301, the ALJ concludes this rule should be applied as written in order to effect

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[18] *See Seminole Pipeline Co., et al, v. Broad Leaf Partners, Inc*, 979 S.W.2d 730, 751 (Civ. App.-Houston [14th] 1998). (By giving effect to the legislative intent, i.e., that the [damages] cap should apply on a "per defendant" basis, we realize our decision renders the statute wholly ineffective in achieving the legislative objective of establishing greater predictability. Still, the task of drafting effective legislation rests with the legislature, not this court.)

[19] 22 Tex Reg. 6264-6305 (July 4, 1997). The preamble to this rule specifies the objectives balanced by the Commission:

> The Commission considered all relevant statutory and policy standards and objectives and designed this new rule to achieve those standards and objectives, including the following:
>
> (1) establish guidelines relating to fees charged or paid for medical services for employees who suffer compensable injuries, including guidelines relating to payment of fees for specific medical treatments or services;
> (2) ensure that injured workers receive the health care reasonably required by the nature of their injury, as and when needed;
> (3) ensure guidelines for medical services fees are fair and reasonable;
> (4) design fee guidelines to ensure quality health care to the injured workers of Texas;
> (5) design fee guidelines to achieve effective medical cost control;
> (6) ensure that guidelines for medical services fees do not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or someone acting on that individual's behalf;
> (7) consider the increased security of payment afforded by the Act in establishing the fee guidelines;
> (8) maintain a statewide database of medical charges, actual payments, and treatment protocols that may be used by the Commission in adopting medical fee guidelines;

the Commission's conclusions on how to carry out the mandates of the Labor Code.[20]

Carrier's evidence on this point, Ms. Shank's testimony, is not determinative notwithstanding her considerable expertise in the field. Any individual author's recollection of the intent of a rule does not substitute for what actually was adopted by the Commission after full opportunity for public comment and Commission reconsideration and revision.[21] Further, Ms. Shank's tenure at the Commission ended in 1996, before the agency implemented the 1997 HFG, so she did not participate in Commission decision-making on application of this rule.

The ALJ concludes that Rule 134.401 does not set up a multi-stage test for a hospital's bill to be considered eligible for reimbursement under the stop-loss alternative. The ALJ concludes that threshold for application of the stop-loss method can be comprehended by application of the plain meaning of the language in the rule. This rule provides for a $40,000 threshold of charges that are the hospital's usual and customary charges, after audit.

2. Permissible Methods to Determine the Audited Charges

Carrier made primarily a legal argument that under its general audit authority it had authority to determine the best means to meet the Commission goals of cost containment, so it could re-price Hospital's charges on implantables.

Hospital relied on the language of Rule 134.401 which does not expressly authorize a carrier to reach into the per diem method in order to recalculate a hospital bill. Hospital also argued that the agency has on many occasions held such a "carve out" is inappropriate.[22]

Based on the agency decisions cited by Hospital in its brief, it appears the conclusion reached by the MRD in this case was consistent with many other Commission decisions on this point. An agency's interpretation of its rule and, by extension, its enabling statue is entitled to some deference.[23]

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(9) ensure the Commission's database contains information necessary to detect practices and patterns in medical charges and actual payments; and
(10) ensure the Commission's database can be used in a meaningful way to allow the Commission to control medical costs as provided by the Act. (22 Tex Reg. 6267)

[20] *See* SOAH Docket Nos. 453-03-1233.M4 (October 2003, Walston) and 453-04-4223.M4 (August 2004, Card).

[21] *General Chemical Corp. vs. De La Lastra*, 852 S.W.2d 916, 923 (Tex. 1993).

[22] See MRD Decisions M4-02-2115-01 (August 15, 2002), M4-02-4514-01 (March 27, 2003), M4-02-4838-01 (April 4, 2003), and M4-03-1552-01 (May 30, 2003), published at www.twcc.state.tx.us.

[23] Contemporaneous construction of a statute by administrative agency charged with its enforcement is entitled to great weight. *State v. PUC*, 883 S.W.2d 190 (Tex. 1994). To be given weight, the agency's interpretation must be reasonable and not contradict the plain language of the statute, *Tarrant Appraisal Dist. v. Moore*, 845 S.W.2d 820 (Tex. 1993); *Dodd v. Meno*, 870 S.W.2d 4 (Tex. 1994), neither expand nor contract the language of the statute, *Firestone Tire & Rubber Co. v. Bullock*, 573 S.W.2d 498 (Tex. 1978), or be clearly inconsistent with legislative intent. ***Texas Water Comm'n v. Brushy Creek MUD,*** 917 S.W.2d 19 (Tex. 1996).

In addition, the internal language and structure of Rule 143.301 seem to prohibit Carrier from recalculating a provider's bill on a line-item basis. First, there is no provision in this rule that permits a carrier to carve out a category of items and apply a pricing or costing method drawn from another category of reimbursement before the bill's qualification for payment under the stop-loss method applies. Second, the language of Rule 134.401 specifies in more than one place that the stop-loss and per diem methods are exclusive of one another.[24] For example, the provision regarding the computation of "additional reimbursements" at cost plus 10 percent for a number of items, including implantables, is applicable "only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."[25] The language in this section is straightforward.

Even considering Carrier's general bill review and audit authority in its most favorable light, the ALJ is unable to find authority for the proposition that Carrier has authority to simply recalculate a line item in a provider's bill by drawing on a methodology from a separate compensation scheme. Auditing authority in the Commission's rules give a carrier a number of ways to challenge the appropriateness or accuracy of a provider's bill, *i.e.*, it contradicts a fee guideline, was not a usual and customary charge, was bundled, *etc.* However, there is nothing in the HFG to suggest what Carrier did in this case is an authorized means of conducting a bill review or that the per diem method to cost "additional items" constitutes a general implantables rate to be used in the auditing process for all purposes.

The ALJ concludes that neither Rule 134.401 nor the general audit authority permit a carrier to recalculate the value of a particular hospital bill line item under the cost plus 10 percent method in order to arrive at the threshold amount of the bill for consideration of stop-loss application.

3. Usual and Customary Charges

Carrier did not present sufficient evidence to show that Hospital's charges were not the same as those that it would have charged any other payor for the same services and items. Neither Ms. Shank nor Dr. Albrecht testified on that point. There were no documents showing that Hospital actually billed another payor a different amount. The MRD concluded the charges were usual and customary.

The ALJ concludes Hospital billed Carrier its usual and customary charges for the services and items used in Claimant's hospitalization.

6. Summary

In summary, the ALJ concludes that Carrier did not act within the scope of its auditing authority when it recalculated Hospital's implantable cost under the cost plus 10 percent method to determine whether Hospital qualified for the stop-loss level of reimbursement. Carrier did not act in accord with Rule 134.302(c)(6) when it denied payment under the stop-loss method on the basis that Hospital had failed to make additional factual showings concerning the nature and extent of the

[24] 28 TEX. ADMIN. CODE § 134.401(c)(6).

[25] 28 TEX. ADMIN. CODE §§ 134.401(c)(4) and (c)(6).

procedure. Carrier did not demonstrate that Hospital's charges were not its usual and customary charges. Based on the above, the ALJ concludes that Carrier should reimburse Hospital the additional amounts that would be due under the stop-loss method of reimbursement provided for in Rule 134.401(c)(6).

II. FINDINGS OF FACTS

1. On ___, ___ (Claimant) suffered a compensable injury to her back.

2. Dillards Department Stores, a self-insured entity (Carrier), was the responsible insurer.

3. On October 23, 2001, Claimant was admitted to Huguley Memorial Hospital (Hospital) as a surgical patient for a six-day stay. She was discharged on October 29, 2001.

4. Claimant was diagnosed as having spinal stenosis, degenerative disk and joint diseases of the lumbar spine, and discogenic and mechanical back pain. Claimant had been treated conservatively during the eight years between her injury and the October 2001 surgery but continued to have back pain.

5. While a patient at the Hospital, Claimant underwent spinal surgery. John A. Sazy, M.D., performed a laminectory, a bilateral foraminotomy, and a posterior spinal fusion at the L1-S1 levels, and an interbody fusion at the L4-5 and L5-S1 levels.

6. The surgery included permanent insertion of various items of instrumentation (implantables) into or near Claimant's spine. The items used in this case included at least two spine-stabilizing meshes or cages into which bone grafts were inserted, screws, a supporting rod, and bone grafting material.

7. Hospital's acquisition cost for the implantable material was $6,603.

8. Hospital supplied the implantables that Dr. Sazy used. Hospital billed Carrier directly for these devices in the amount of $69,743.80. The total bill for the hospital stay, including implantables, was $94,689.05.

9. All charges made by Hospital were that facility's usual and customary charges for services and items provided for a surgical admission.

10. Claimant began walking three days after the operation, and for the remaining four days increased her walking, endurance, and stamina. She did not suffer any reverses, infections, or other complications of the surgery while a Hospital patient.

11. Carrier did not conduct an on-site audit of Hospital's bill for Claimant's care; Carrier conducted a bill review limited to Hospital's qualification for stop-loss reimbursement.

12. In its bill review, Carrier determined that Claimant's hospital stay was not lengthy, and that the services provided were neither unusually extensive or costly treatment for the spine condition Claimant presented. The amount billed for service, exclusive of implantables, was $24,945.25, which Carrier determined not sufficient to meet the dollar threshold of $40,000.

13. Carrier reimbursed Hospital $13,971.30 and denied payment for all amounts above that amount the basis that the charges were inconsistent with Commission's Acute Care Inpatient Hospital Fee Guideline (HFG), 28 TEX. ADMIN. CODE § 134.401.

14. Carrier arrived at the reimbursement amount of $13,971.30 by first recalculating the value of the implantables at cost plus 10 percent, a method provided for in 28 TEX. ADMIN. CODE § 134.401(c)(4) for additional items under the per diem method. It also recalculated the cost for basic hospital services using the daily rate of $1,118 for surgical admissions under the per diem method. The amount of the former was $7,263.30, and the amount of the latter was $6,708.00.

15. The only purpose stated in the HFG for cost plus 10 percent valuation of implantables is as a means of supplementing the per diem charges for certain qualifying items when the per diem reimbursement method is used.

16. On January 30, 2004, the MRD ordered Carrier to reimburse Hospital an additional $57,045.48, which would compensate Hospital at the rate provided for under the stop-loss method of reimbursement. The MRD held that Carrier had incorrectly carved out the implantable costs before it determined which reimbursement method to apply under the HFG and also held that Hospital's charges were usual and customary.

17. On February 4, 2004, Carrier requested a hearing on the MRD decision.

18. On March 2, 2004, the Commission issued a notice of hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted. The case was continued on motion of the parties.

19. Administrative Law Judge Cassandra Church conducted a hearing on the merits of this case on August 25, 2004, and the record closed September 3, 2004, the date the parties filed closing argument.

III. 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. § 413.031 and TEX. GOV'T CODE ANN. ch. 2003.

2. Carrier timely requested a hearing, as specified in 28 TEX. ADMIN. CODE § 148.3.

3. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. Carrier, as the petitioning party, has the burden of proof in this proceeding pursuant to TEX. LAB. CODE ANN. § 413.031 and 28 TEX. ADMIN. CODE § 148.21(h).

5. Carrier failed to meet its burden of proof to show it had authority under 28 TEX. ADMIN. CODE 134.401 to use the cost plus 10 percent method to recalculate the value of implantables supplied by Hospital to order to determine Hospital's qualification for payment under the stop-loss method.

6. Carrier failed to meet its burden of proof to show it had authority under 28 TEX. ADMIN. CODE §§ 133.301 or 134.401 to use the per diem method to reimburse Hospital for Claimant's surgical hospital admission from October 23-29, 2001.

7. Hospital's charges of $94,689.05 for Claimant's surgical hospital admission from October 23-29, 2001, met the threshold for reimbursement under the stop-loss method of compensation set forth in 28 TEX. ADMIN. CODE § 134.401(c)(6).

ORDER

IT IS ORDERED that Dillards Department Stores, a self-insured entity, reimburse Hugely Memorial Hospital a total of $57,045.48, plus accrued interest, for Claimant ___'s surgical hospital admission from October 23-29, 2001.

SIGNED November 2, 2004.

CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX 9

TAB 9

State Office of Administrative Hearings

Shelia Bailey Taylor
Chief Administrative Law Judge

February 23, 2007

TO ALL PARTIES OF RECORD:

Re: Consolidated Stop-Loss Legal Issues Docket, SOAH Docket No. 453-03-1487.M4 (Lead Docket)

Dear Counsel and Parties:

On February 9, 2007, James M. Loughlin filed a Request for Clarification. No other correspondence regarding the Request for Clarification has been filed. The En Banc Panel believes "the hospital's usual and customary" and "a hospital's usual and customary" are clear. They refer to the hospital's own "usual and customary charges" and do not refer to any other charges such as an average or median of other hospitals' charges. As to "any applicable MARS," if there are no applicable maximum allowable reimbursements for inpatient hospital charges as suggested in the Request for Clarification, then no clarification is necessary.

Sincerely,

Catherine C. Egan

Catherine C. Egan
Administrative Law Judge

CCE/vg
xc: Parties (service list) -**VIA FACSIMILE OR VIA REGULAR MAIL**

APPENDIX 10

TAB 10

SOAH DOCKET NO. 453-05-9670.M4
TWCC MDR NO. M4-05-9507-01

RIO GRANDE REGIONAL HOSPITAL,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
TEXAS MUTUAL INSURANCE	§	
COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Rio Grande Regional 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 to 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 Judges (ALJs) find the Stop-Loss Exception should be followed in this proceeding. Accordingly, Texas Mutual Insurance Company (Carrier) is ordered to pay additional reimbursement in the amount of $84,638.58, plus any applicable interest.

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[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 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 August 9, 2005. Petitioner filed a timely and sufficient request for hearing. Notice of the hearing was appropriately issued to the parties. The hearing convened and concluded on June 21, 2007.[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 $125,432.90 based on Provider's usual and customary charges for the inpatient stay and surgical procedure. The bill included $90,230.00 for surgical implantables. To date, Carrier has paid $9,436.10.

B. Issues

1. Summary of Positions and ALJs' Decision

In summary, the parties' positions and ALJs' 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	$125,432.90	$125,432.90	$125,432.90	**$125,432.90**
75% Stop Loss Methodology	applied standard per diem rate [4]	x 75%	applied a modified per diem rate[5]	**x 75%**
Reimbursement Amount	$4,472.00	$94,074.68	$9,436.10	**$94,074.68**
Less Payment	($9,436.10)	($9,436.10)	($9,436.10)	**($9,436.10)**
Balance Due Provider	$0.00	$84,638.58	$0.00	**$84,638.58**

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."[6] The following legal issues in this case were decided by a SOAH En Banc Panel[7] (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.

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[4] MRD calculated the reimbursement on the per diem calculation (4 days @ $1,118.00 per day), for a total reimbursement of $4,472.00. MRD did not recommend reimbursement for implantables because Provider did not submit invoices. It was MRD's position and Carrier's contention that Provider is not entitled to additional reimbursement because the hospitalization did not require unusually extensive services.

[5] Carrier reimbursed 4 days at $795.50 per day for a total of $3,182.00. Carrier reimbursed $1,290.00 for pharmacy and $4,964.10 for implantables. Under the 1997 ACIHFG, the per diem rate for medical is $870.00 and $1,118.00 for surgical. Therefore, it does not appear that Carrier paid the correct amount under its per diem position.

[6] 28 TEX. ADMIN. CODE (TAC) § 134.401(c)(6).

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

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.

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.[8] Provider is required to charge its usual and customary charges, and Provider proved the charges it assessed were Provider's usual charges for that particular item or service.

In summary, the ALJs conclude that the Stop-Loss Threshold was met in this case and that the amounts in dispute should be calculated accordingly.

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[8] 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 his employment; his employer had coverage with Texas Mutual Insurance Company (Carrier).

2. Rio Grande Regional Hospital (Provider) provided medical treatment to Claimant for the compensable injury.

3. Provider submitted itemized billing totaling $125,432.90 for the services provided to Claimant for the treatment in issue.

4. Provider's bill included charges in the amount of $90,230.00 for surgical implantables used to treat Claimant.

5. The $125,432.90 billed was Provider's usual and customary charges for these items and treatments.

6. Carrier did not perform an on-site audit of the bill but did conduct a desk audit.

7. Other than reimbursing the Provider's bill according to a modified per diem methodology, no other audit reductions were made.

8. Carrier has issued payments of $9,436.10 to Provider for the services in question.

9. Carrier denied further reimbursement to Provider.

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

11. 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.

12. MRD issued its Findings and Decision, holding that no further reimbursement was owed by Carrier.

13. Provider timely filed a request for a contested case hearing on the MRD's decision.

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

15. On June 21, 2007, Administrative Law Judges Howard S. Seitzman and Tommy L. Broyles 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 on June 21, 2007.

16. Provider's total audited charges under § 134.401(c)(6)(A)(v) are $94,074.68, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

17. Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $94,074.68. After deduction of Carrier's prior payment of $9,436.10, Provider is entitled to additional reimbursement of $84,638.58, 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 according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. Petitioner had the burden of proof in this proceeding pursuant 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 for the cases subject to this order.

17. Applying the Stop-Loss Methodology in this case, Provider is entitled to total reimbursement of $94,074.68.

18. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $9,436.10 of this amount.

19. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $84,638.58, plus any applicable interest.

ORDER

It is hereby **ORDERED** that Texas Mutual Insurance Company reimburse Rio Grande Regional Hospital the additional sum of $84,638.58, plus any applicable interest, for services provided to Claimant.

SIGNED August 9, 2007.

HOWARD S. SEITZMAN
TOMMY L. BROYLES
ADMINISTRATIVE LAW JUDGES
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX 11

TAB 11

State Office of Administrative Hearings

Shelia Bailey Taylor
Chief Administrative Law Judge

January 7, 2008

John Pringle, Attorney At Law
Law Office Of John D Pringle
807 Brazos, Suite 603
Austin, TX 78701

VIA REGULAR MAIL

Cristina Y Hernandez, Attorney At Law
The Carter Law Firm
1314 Texas Avenue, Suite 1110
Houston, IX 77002

VIA REGULAR MAIL

RE: Docket No 453-05-2804.M5; P.E.I.C. V. V.M C.H.

Dear Parties:

Enclosed please find the Decision and Order in the above-referenced case.

Sincerely,

James W. Norman
Administrative Law Judge

JWN/cm
Enclosure
xc: Sylvia Sanchez, Texas Department of Insurance, Division of Workers' Compensation, Legal Services Division, 7551 Metro Center Drive, Ste 100, MS-11, Austin, Texas 78744-1609- **VIA INTERAGENCY MAIL**
David Bragg, Attorney At Law, Bragg, Chumlea, McQuality & Smithers, 823 Congress Ave, Suite 1100, Austin, IX 78701- **VIA REGULAR MAIL**

SOAH DOCKET NO. 453-05-2804.M5
TWCC MDR NO. M5-04-3451-01

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

DECISION AND ORDER

Pacific Employers Insurance Company (Carrier) and Vista Medical Center Hospital (Provider) each 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, but less than Provider requested, for a hospital stay provided to Claimant, an injured worker. Provider contended that reimbursement 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] Carrier argued that payment should not be based on the Stop-Loss Exception, but asserted that if the Stop-Loss Exception is found to apply, the amount owed should be reduced for the reasons discussed below. The Administrative Law Judges (ALJs) find the Stop-Loss Exception should be followed and Carrier should be ordered to pay additional reimbursement of $42,937.36, plus any applicable interest.[3]

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[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.

[3] ALJ Tommy L. Broyles presided at the hearing. ALJ James W. Norman reviewed the entire record and wrote this decision. ALJ Howard S. Seitzman has reviewed the decision. (It appears that an approximate nine to ten second portion of the hearing, dealing with testimony on duplicate charges, was not recorded. The ALJs believe this testimony would not change the ultimate recommendation.)

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on October 7, 2004 [4] Carrier and Provider both filed timely and sufficient requests for hearing Notice of the hearing was appropriately issued to the parties The hearing convened and concluded on November 15, 2007 [5] The record closed on that date

II. DISCUSSION

A. Factual Overview

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 $71,568 65 based on Provider's usual and customary charges for the inpatient stay and surgical procedure To date, Carrier has paid $10,722 07

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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[4] MRD issued an earlier decision on April 30, 2004, that it withdrew on June 8, 2004

[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

	MRD	Provider	Carrier	ALJ
Charges	$71,568.65	$71,568 65	$71,568.65	**$71,568.65**
Reimbursement Methodology	modified Stop-Loss[6]	x 75%	per diem	**x 75%**
Reimbursement Amount	$35,192 78	$53,676 49	$10,722 07[7]	**$53,676.49[8]**
Less Payment	($5,979 80)	($5,979 80)	($10,722.07)	**($10,722.07)**
Balance Due	$29,212.98	$47,979.80	$0.00	**$42,954.42**

[6] MRD determined that the Stop-Loss Exception applied, but reduced the payable amount because (1) Provider did not submit records to challenge Carrier's positions that implantables should be paid at cost plus 10 percent; (2) ICU/CCU charges should be reduced as unnecessary per an INTRACORP nurse review; and (3) certain amounts billed were an overcharge, excessive charge, unreasonable charge, duplicate charge, or "unbundled." MRD reduced the amount payable to $46,923 71, multiplied that amount times 75 percent, and subtracted $5,979 80 as already paid

[7] Carrier based its payment on implantables at cost plus 10 percent, an amount for inpatient services, and an ICU stay Ex P-1 at 46 The parties disagreed over the amount actually paid MRD said Carrier paid $5,979 80 based on Carrier's initial explanation of benefits (EOB) However, a Carrier witness testified that Carrier's records show $10,722 07 in payments This showing $10,722 07 as the amount Carrier actually paid is most persuasive

[8] Carrier's witness testified that Provider submitted $5,835.86 in duplicate charges, $2,185 23 for an extra day in the hospital that was not preauthorized, and $2,600.00 for an ICU stay that was not preauthorized Carrier contended it should not be required to pay for these charges (and unbundling charges) and that the ICU charge should be reduced to $715 00 for a non-ICU stay The ALJs were not persuaded by Carrier's contentions. Provider charged only three hospital days and Carrier approved an ICU charge Ex V-1 at 2, 12, 16 Further, an insurer's reasons for denying claims are limited to reasons stated before a medical dispute resolution request 28 TAC § 133 307(j)(2) (in effect at time of dispute) Carrier did not deny any of the claims because of an extra day's stay, an ICU stay, or unbundling

In its second EOB, Carrier used duplicate-bill denial code "D" to reduce implantable charges to cost plus 10 percent Ex P-1 at 46 None of the charges that Carrier identified at the hearing as duplicates relate to implantables Thus, Carrier's denial reasons for duplicate charges do not comply with the above-described 28 TAC § 133 307(j)(2). (Carrier's peer review doctor, Alan Strizak, M D., opined that the records document "excessive and unreasonable charges and/or duplication of charges for [a number of items]" Ex V-1 at 31 Dr Strizak's opinion is unspecific on the issue of duplicate charges)

Carrier cited testimony from Provider witness Rita Morales, whose job is to supervise the issuance of Provider's bills, as demonstrating that Provider did not prove it billed its usual and customary charges However, although the evidence showed that Ms Morales may not be aware of how Carrier determines its implantables charges, she is aware of what Provider's usual and customary charges are and that it charged those amounts in this case

Per the En Banc Panel decision, the ALJs were unpersuaded by MRD's decisions that implantables should be reduced to cost plus 10 percent They were unpersuaded that preauthorized services may be denied as unnecessary In view of the Stop-Loss requirement that providers be paid 75 percent of total audited charges above $40,000 00, they were unpersuaded by MRD's findings concerning unreasonable and excessive charges and overcharges

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)(6) 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

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[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

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 particular items or service.

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 An injured worker (Claimant) sustained a compensable injury in the course and scope of his employment; his employer had coverage with Pacific Employers Insurance Company (Carrier)

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

3. Provider submitted itemized billing totaling $71,568 65 for the services provided to Claimant for the treatment in issue.

4. The $71,568 65 billed was Provider's usual and customary charges for these items and treatments

5. Carrier has issued payments of $10,722 07 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)

---

[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

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 the Stop-Loss Exception applied, but reduced the payable amount because (a) Provider did not submit records to challenge Carrier's positions that implantables should be paid at cost plus 10 percent; (b) ICU/CCU charges should be reduced as unnecessary per an INTRACORP nurse review; and (c) certain amounts billed were an overcharge, excessive charge, unreasonable charge, duplicate charge, or "unbundled."

10. Carrier and Provider each 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 November 15, 2007, Administrative Law Judge Tommy L. Broyles 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 on November 15, 2007, and the record closed the same day.

13. Carrier contended that any amount it owes should be reduced for certain duplicate charges, and an extra day in the hospital and ICU stay that were not preauthorized.

14. The matters Carrier asserted in Finding of Fact No. 13 are reasons for denial of a claim that were not asserted by Carrier before a request for medical dispute resolution.

15. Provider charged for a three-day hospital admission, including the ICU stay.

16. Carrier preauthorized a three-day hospital admission and approved and paid the ICU charge.

17. Provider's total audited charges under § 134.401(c)(6)(A)(v) are $71,568.65, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

18. Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $53,676.49. After deduction of Carrier's prior payment of $10,722.07, Provider is entitled to additional reimbursement of $42,937.36, 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 Petitioner 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 § 134.401(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 for this case

17 If a specified health care treatment or service is preauthorized, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service. TEX. LAB CODE ANN § 413 014

18 Applying the Stop-Loss Methodology in this case, Provider is entitled to total reimbursement of $53,676 49

19 As specified in the above Findings of Fact, Carrier has already reimbursed Provider $10,722 07 of this amount

20 Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $42,954 42, plus any applicable interest

ORDER

It is hereby **ORDERED** that Pacific Employers Insurance Company reimburse Vista Medical Center Hospital the additional sum of $42,954 42, plus any applicable interest, for services provided to Claimant

SIGNED January 7, 2008.

JAMES W. NORMAN
TOMMY L. BROYLES
HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGES
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX 12

TAB 12

State Office of Administrative Hearings

Shelia Bailey Taylor
Chief Administrative Law Judge

May 22, 2008

John D Pringle
Pringle & Gallagher, L L P
The Vaughn Building
807 Brazos Street, Suite 200
Austin, Texas 78701

VIA REGULAR MAIL

Cristina Y Hernandez
The Carter Law Firm
1314 Texas Avenue, Ste 1110
Houston, Texas 77002

VIA REGULAR MAIL

RE: Docket No. 453-05-9025.M5; DWC MR. No. M5-05-2400-01; Ace Insurance Company of Texas v. Vista Medical Center Hospital

Dear Parties:

Enclosed please find the Decision and Order in the above-referenced case

Sincerely,

Tommy L Broyles
Administrative Law Judge

TLB/ls
Enclosure
xc: Sylvia Sanchez, Texas Department of Insurance, Division of Workers' Compensation, Legal Services Division, 7551 Metro Center Drive, Ste 100, MS-11, Austin, Texas 78744-1609 - **VIA INTERAGENCY MAIL**
David F Bragg, Attorney, Law Office of David F Bragg, P C , 211 East 7th Street, Ste. 920, Austin, TX 78701 - **VIA REGULAR MAIL**

SOAH DOCKET NO. 453-05-9025.M5
TWCC MRD NO. M5-05-2400-01

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

DECISION AND ORDER

Ace 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] awarding additional reimbursement to Vista Medical Center Hospital (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 followed in this proceeding and Carrier is ordered to pay an additional reimbursement of $71,318.77 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 or the Stop-Loss Rule.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on July 18, 2005 Petitioner filed a timely and sufficient request for hearing Notice of the hearing was appropriately issued to the parties The hearing convened and concluded on April 8, 2008.[3]

II. DISCUSSION

A. Factual Overview

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 $228,044 50 for the inpatient stay and surgical procedure To date, Carrier has paid $62,700 15.

B. Issues

1. 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

[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

costly services rendered during treatment to an injured worker."[4] The following legal issues in this case were decided by a SOAH En Banc Panel[5] (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.

a. 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.

b. 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.

c. 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).

d. The ALJs find that a hospital establishes eligibility for applying the Stop-Loss Methodology under § 134.401(c)(4)[6] 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.

---

[4] 28 TAC § 134.401(c)(6).

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

[6] Because of a typographical error, the En Banc Panel's decision 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.[7]

2. Summary of Positions and ALJ's Decision

After a review of the evidence, the ALJ finds the audited charges exceed the $40,000 Stop-Loss threshold. Carrier performed a desk audit suggesting the charges should be reduced by $157,762 28. However, Carrier has the burden of proof in this case and proved only a reduction of $49,352.61 as justified. The excluded amount concerns unbundling and failure to produce documentation in support of charges. The appropriate charges are accordingly reduced to $178,691 89. Carrier failed to prove-up all other reductions it made. In summary, the parties' positions and ALJ's findings are as follows:

	MRD	Provider	Carrier	ALJ
Charges	$157,954 50	$228,044 50	$228,044 50	**$228,044.50**
Charges after Audit	N/A	N/A	$70,282.22	$178,691.89
Methodology Applied	stop-loss[8]	stop loss	unclear	**stop loss**
Reimbursement Amount	$118,465 87	$171,033 38	$62,700 15	**$134,018.92**
Less Payment	($62,700 15)	($62,700 15)	($62,700 15)	**($62,700.15)**
Balance Due Provider	$55 765.72	$108,333.23	$0 00	**$71,318.77**

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

[8] MRD applied the Stop-Loss Exception but only had $157,954 50 in dispute before them.

In summary, because Provider's audited charges were in excess of $40,000 00, the Stop-Loss Exception is applicable and the amounts in dispute should be calculated accordingly

III. FINDINGS OF FACT

1 Claimant sustained a compensable injury in the course and scope of his employment; his employer had coverage with Ace Insurance Company of Texas (Carrier)

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

3 Provider submitted itemized billing totaling $228,044 50 for the services provided to Claimant for the treatment in issue

4 Per audit reduction, the total charges should be reduced by $49,352 61

5 Carrier issued payments of $62,700 15 to Provider for the services in question

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

7 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

8 MRD issued its Findings and Decision, holding that reimbursement of $118,465 87 was owed by Carrier

9 Provider timely filed a request for a contested case hearing on MRD's decision

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

11 On April 8, 2008, Administrative Law Judge Tommy L Broyles 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 on that same day

12 Provider's total audited charges are $178,691.89, which allows Provider to obtain reimbursement under the Stop-Loss methodology.

13 Under the Stop Loss methodology, Provider is entitled to total reimbursement of $134,018.92. Because Carrier has paid $62,700.15, Provider is entitled to an additional reimbursement of $71,318.77.

IV. CONCLUSIONS OF LAW

1 SOAH 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. 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 § 134.401(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 MAR 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 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).

9 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 or

10 Provider 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.

11 The Stop-Loss Methodology applies to this case.

12. Provider is entitled to total reimbursement of $134,018.92.

13 As specified in the above Findings of Fact, Carrier has reimbursed Provider $62,700.15.

14 Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $71,318.77.

ORDER

It is hereby **ORDERED** that Ace Insurance Company of Texas reimburse Vista Medical Center Hospital an additional $71,318.77, plus applicable interest, for services provided to Claimant.

SIGNED May 22, 2008.

TOMMY L. BROYLES
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX 13

TAB 13

10110-595

C

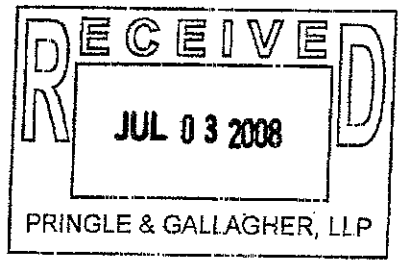
State Office of Administrative Hearings

Shelia Bailey Taylor
Chief Administrative Law Judge

July 1, 2008

John D. Pringle
Pringle & Gallagher, L.L.P.
The Vaughn Building
807 Brazos Street, Suite 200
Austin, Texas 78701

VIA REGULAR MAIL



Eric G. Carter
The Carter Law Firm
1314 Texas Avenue, Ste. 1110
Houston, Texas 77002

VIA REGULAR MAIL

RE: Docket No. 453-05-7487.M4; DWC MR. No. M4-05-5230-01; Ace Insurance Company of Texas v. Vista Medical Center Hospital

Dear Parties:

Enclosed please find the Decision and Order in the above-referenced case.

Sincerely,

Tommy L. Broyles
Administrative Law Judge

ILB/ls
Enclosure
xc: Sylvia Sanchez, Texas Department of Insurance, Division of Workers Compensation, Legal Services Division, 7551 Metro Center Drive, Ste. 100, MS-11, Austin, Texas 78744-1609 - **VIA INTERAGENCY MAIL**
David F. Bragg, Attorney, Law Office of David F. Bragg, P.C., 211 East 7th Street, Ste. 920, Austin, TX 78701 - **VIA REGULAR MAIL**

CONFIDENTIAL
Pursuant to TEX. LAB. CODE ANN.
§ 402.083

SOAH DOCKET NO. 453-05-7487.M4
MDR NO. M4-05-5230-01

ACE INSURANCE COMPANY OF TEXAS, Petitioner	§	BEFORE THE STATE OFFICE
	§	OF
V.	§	
VISTA MEDICAL CENTER HOSPITAL, Respondent	§	ADMINISTRATIVE HEARINGS

DECISION AND ORDER

Ace 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] granting additional reimbursement for a hospital stay provided to Claimant, an injured worker, by Vista Medical Center Hospital (Provider). Carrier argued that reimbursement for this admission should not 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 $35,157.04, 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 or the Stop-Loss Rule.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on June 1, 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 May 15, 2008 [3] The record closed on the 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 $130,418 73 based on Provider's usual and customary charges for the inpatient stay and surgical procedure To date, Carrier has paid $57,107 01

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	ALJs
Charges	$130,418.73	$130,418.73	$130,418.73	**$130,418.73**
Audited charges	$130,418.73	$130,418.73	$57,107.01	**$123,018.73**
Reimbursement Methodology	stop loss	stop loss	unclear	**stop loss**
Reimbursement Amount	$97,814 05	$97,814 05	$57,107 01	**$92,264.05**
Less Payment	($57,107.01)	($57,107.01)	($57,107.01)	**($57,107.01)**
Balance Due Provider	$40,707.04	$40,707 04	$0	**$35,157.04**

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.[4] The following legal issues in this case were decided by a SOAH En Banc Panel[5] (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.

[4] 28 IAC § 134 401(c)(6)

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

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.[6]

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.[7] Provider charged its usual and customary charges for the items and services provided at issue in this case.

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[6] 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

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

In summary, because the amount billed exceeds $40,000, the ALJ concludes that the Stop-Loss Threshold was met 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 Ace Insurance Company of Texas (Carrier)

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

3. Provider submitted itemized billing totaling $130,418.73 for services provided to Claimant

4 Carrier issued payments of $57,107.01 to Provider for the services in question

5 Carrier denied further reimbursement to Provider

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

7. 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.

8. MRD issued its Findings and Decision holding that the additional amount of $40,707.04 was owed

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

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

11. On May 15, 2008, Administrative Law Judge Tommy L. Broyles 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 on that same day

12. Provider's total audited charges under § 134.401(c)(6)(A)(v) are $123,018.73, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

13 Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $92,264.05. After deduction of Carrier's prior payment of $57,107.01, Provider is entitled to reimbursement of $35,157.04, plus any applicable interest, under the Stop-Loss Methodology.

IV. CONCLUSIONS OF LAW

1. SOAH 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 § 134.401(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 MAR 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 § 34.401(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 Provider 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 preamble 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 $92,264.05.

18 As specified in the above Findings of Fact, Carrier has already reimbursed Provider $57,107.01.

19 Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $35,157.04, plus any applicable interest.

ORDER

It is hereby **ORDERED** that Ace Insurance Company of Texas reimburse Vista Medical Center Hospital the additional sum of $35,157 04, plus any applicable interest, for services provided to Claimant

SIGNED July 1, 2008.

TOMMY L. BROYLES
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX 14

TAB 14

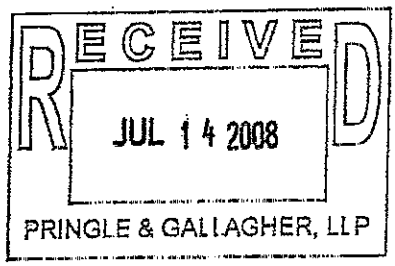
10110-609

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

July 11, 2008

John Pringle
Attorney
Pringle & Gallagher, LLP
The Vaughn Building
807 Brazos, Ste 200
Austin, TX 78701



VIA REGULAR MAIL

William Carter
Attorney
The Carter Law Firm
211 East 7th St., Ste 920
Austin, TX 78701

VIA REGULAR MAIL

RE: Docket No. 453-05-9178.M4; MDR No. M4-04-6002-01; Vista Medical Center Hospital v. Pacific Employers Insurance Company;

Dear Parties:

Enclosed please find the Decision and Order in the above-referenced case

Sincerely,

James W. Norman
Administrative Law Judge

JWN/sb
Enclosure
xc: Sylvia Sanchez, Texas Department of Insurance, Division of Workers- Compensation, Legal Services Division, 7551 Metro Center Drive, Ste 100, MS-11, Austin, Texas 78744-1609- **VIA INTERAGENCY MAIL**

CONFIDENTIAL
Pursuant to TEX. LAB. CODE ANN. § 402.083

SOAH DOCKET NO 453-05-9178.M4
MDR NO. M4-04-6002-01

VISTA MEDICAL CENTER HOSPITAL, Petitioner	§	BEFORE THE STATE OFFICE
V.	§	OF
PACIFIC EMPLOYERS 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, Pacific Employers Insurance Company (Carrier) is ordered to pay additional reimbursement in the amount of $81,654 70, 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 or the Stop-Loss Rule

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on July 12, 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 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 $135,159 06 based on Provider's usual and customary charges for the inpatient stay and surgical procedure To date, Carrier has paid $19,638 80

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	$135,159.06	$135,159.06	$135,159.06	**$135,159.06**
Audited Charges		$135,159.06		**$135,056.94**[4]
Reimbursement Methodology	per diem[5]	x 75%[6]	per diem[7]	**x 75%**[8]
Reimbursement Amount	$13,470.50	$101,369.30	$19,638.80	**$101,292.70**

[4] See footnote 8 for an explanation of audited charges

[5] MRD determined that the Stop-Loss Exception did not apply since the admission did not involve "unusually extensive services." It calculated per-diem reimbursement of $7,833.00 (7 day @ $1,118.00 per day = $7,833.00) plus $5,637.50 for implantables at cost plus 10 per cent ($5,125.00 x 110%) for a total reimbursement of $13,470.50. It noted that Carrier used denial code "U" to deny some services as medically unnecessary. Citing 28 TAC § 133.301(a), it said the services could not be denied on the basis of a lack of medical necessity because they were preauthorized.

[6] Provider argued it is entitled to payment under the Stop-Loss Methodology at 75 percent of total audited charges. It contended that Carrier may not assert that some of the hospital-stay days were not preauthorized because Carrier did not appeal MRD's decision that the services were preauthorized.

[7] Carrier paid $19,638.80 for the services. It contended that it if the Stop-Loss Exception is found to apply, it should be required to pay for only the three days hospitalization that it preauthorized (Provider Ex. 1 at 55). According to the explanation of benefits (EOB) in Provider's evidence, Carrier declined payment under denial code "U," explained as "documentation does not support charges" and "M," explained as "per diem rate applied in accordance with the acute care inpatient hospital fee guideline for the State of Texas." (Provider Ex. 1 at 18-19.) According to Carrier's records, Carrier also denied the following services for other reasons: under denial code "G," explained as "Included in visit procedure rendered on this day," a $94.22 charge for durable medical equipment (May 8, 2003), a $7.90 charge for surgical supply (May 8, 2003) and a $10.00 charge for a "handling conveyance" service (May 14, 2008) (Carrier Ex. 1 at 50, 57); and under denial code "C," explained as "negotiated contract," a $463.52 reduction from a $480.00 charge for water circulating heat/AC (May 14, 2008) (Carrier Ex. 1 at 57). (The May 14, 2008 services were not shown on Provider's bill as being part of Provider's $135,159.06 charges at issue (Provider Ex. 1 at 9, 10, 14-15.)

[8] Carrier's use of denial code "M" was inconsistent with the Stop-Loss Exception. Its use of denial code "U" was inconsistent with its preauthorization of the services—its contention that only some of the services were preauthorized could not be considered because it was not raised as a ground for denial before Provider's request for medical dispute resolution. (The Division's rules at 28 TAC § 133.307(j)(2), in effect at the time of the dispute, provided that a new reason for denial not raised before the request for medical dispute resolution may not be considered.) The items that Carrier denied on May 14, 2003, do not appear to be part of the charges at issue.

The items that Carrier denied on May 8, 2003, totaling $102.12, should be deducted from Provider's total charges because Carrier claimed they were global to other charges. Provider had the burden of proof. It failed to prove these charges were not global to other charges.

Less Payment	($19,638 80)	($19,638 80)	($19,638 80)	**($19,638.80)**
Balance Due Provider	$0 00	$81,730 50	$0 00	**$81,654.70**

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,

[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

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]

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 Pacific Employers Insurance Company (Carrier).

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

3. Provider submitted itemized billing totaling $135,159.06 for services provided to Claimant.

4. The $135,159.06 billed was Provider's usual and customary charges for these items and treatments.

5. Carrier issued payments of $19,638.80 to Provider for the services in question.

[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.

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 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 concluded that day and the record closed on May 27, 2008.

13 Provider's total audited charges under § 134.401(c)(6)(A)(v) are $135,056.94, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology.

14 Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $101,292.70. After deduction of Carrier's prior payment of $19,638.80, Provider is entitled to additional reimbursement of $81,654.70, 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)(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 $101,292.70.

18. As specified in the above Findings of Fact, Carrier has already reimbursed Provider $19,638.80 of this amount.

19. Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $81,654.70, plus any applicable interest.

ORDER

It is hereby **ORDERED** that Pacific Employers Insurance Company reimburse Vista Medical Center Hospital the additional sum of $81,654.70, plus any applicable interest, for services provided to Claimant.

SIGNED July 11, 2008.

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

APPENDIX 15

TAB 15

10110-6666

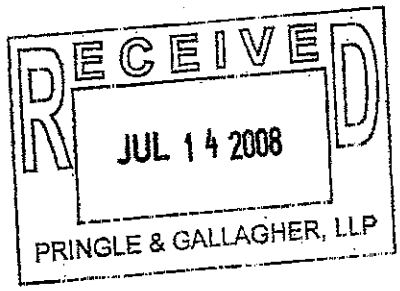
State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

July 11, 2008

Cristina Hernandez
Attorney
The Carter Law Firm – Houston Office
1314 Texas Avenue, Suite 1110
Houston, TX 77002

VIA REGULAR MAIL



John D Pringle
Attorney
Pringle & Gallagher, LLP
The Vaughn Building
807 Brazos, Ste 200
Austin, TX 78701

VIA REGULAR MAIL

RE:Docket No. 453-05-5471.M4; MR No M4-04-4885-01;Vista Medical Center Hospital v. Pacific Employers Insurance Company

Dear Parties:

Enclosed please find the Decision and Order in the above-referenced case

Sincerely,

James W Norman
Administrative Law Judge

JWN/sb
Enclosure
xc: Sylvia Sanchez, Texas Department of Insurance, Division of Workers- Compensation, Legal Services Division, 7551 Metro Center Drive, Ste 100, MS-11, Austin, Texas 78744-1609- VIA INTERAGENCY MAIL

Post Office Box 13025 ◆ William P Clements Building 300 West 15th Street, Suite 502 ◆ Austin Texas 78711-3025
(512) 475-4993 Docket (512) 475-3445 Fax (512) 475-4994
http://www.soah.state.tx.us

CONFIDENTIAL
Pursuant to TEX. LAB. CODE ANN. § 402.083

SOAH DOCKET NO. 453-05-5471.M4
MDR NO. M4-04-4885-01

VISTA MEDICAL CENTER HOSPITAL, Petitioner	§	BEFORE THE STATE OFFICE
V.	§	OF
PACIFIC EMPLOYERS 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, Pacific Employers Insurance Company (Carrier) is ordered to pay additional reimbursement in the amount of $28,767.09, 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 or the Stop-Loss Rule.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The MRD issued its decision on March 17, 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 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 $122,261 45 based on Provider's usual and customary charges for the inpatient stay and surgical procedure To date, Carrier has paid $62,929 00

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	$122,261.45	$122,261.45	$122,261.45	**$122,261.45**
Reimbursement Methodology	per diem[4]	x 75%	Unclear[5]	**x 75%**[6]
Reimbursement Amount	$17,146.00	$91,696.09	$62,929.00	**$91,696.09**
Less Payment	($62,929.00)	($62,929.00)	($62,929.00)	**($62,929.00)**
Balance Due Provider	$0.00	$28,767.09	$0.00	**$28,767.09**

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."[7] The following legal issues in this case were decided by a SOAH En Banc Panel[8] (En Banc Panel), and those determinations are

[4] MRD determined that the Stop-Loss Exception did not apply since the admission did not involve "unusually extensive services." MRD calculated reimbursement based on the per diem methodology (1 day of intensive care at $1,560.00 plus 3 days of surgical at $1,118.00 per day for a payment of $4,914.00). MRD said Provider was entitled to additional reimbursement of $12,232.00 for implantables, calculated at cost plus 10 percent, for total reimbursement of $17,146.00. Based on Carrier's payment, MRD determined that no additional reimbursement was owed.

[5] Carrier paid $57,716.00 for implantables, $1,560.00 for ICU, $3,354.00 for a surgical admission, and $299.00 for blood. It denied the remainder of Provider's charges based on denial code "F," explained as a reduction according to medical fee guideline.

[6] Provider's charges qualify for payment under the Stop-Loss Methodology. Carrier's use of denial code "F" is inconsistent with the payment methodology under the Stop-Loss Exception.

[7] 28 TAC § 134.401(c)(6).

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

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.[9]

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.[10] Provider charged its usual and customary charges for the items and services provided.

[9] 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.

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

12 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 concluded that day and the record closed on May 27, 2008

13 Provider's total audited charges under § 134 401(c)(6)(A)(v) are $122,261 45, which allows Provider to obtain reimbursement under the Division's Stop-Loss Methodology

14 Under the Stop-Loss Methodology, Provider is entitled to total reimbursement of $91,696 09 After deduction of Carrier's prior payment of $62,929 00, Provider is entitled to additional reimbursement of $28,767 09, 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)(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 $91,696.09.

18 As specified in the above Findings of Fact, Carrier has already reimbursed Provider $62,929.00 of this amount.

19 Based on the foregoing findings of fact and conclusions of law, Carrier owes Provider an additional reimbursement of $28,767.09, plus any applicable interest.

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 Pacific Employers Insurance Company (Carrier).

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

3 Provider submitted itemized billing totaling $122,261.45 for services provided to Claimant.

4. The $122,261.45 billed was Provider's usual and customary charges for these items and treatments.

5 Carrier issued payments of $62,929.00 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.

ORDER

It is hereby **ORDERED** that Pacific Employers Insurance Company reimburse Vista Medical Center Hospital the additional sum of $28,767.09, plus any applicable interest, for services provided to Claimant.

SIGNED July 11, 2008.

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

APPENDIX 16

TAB 16

MDR Tracking Number: M4-03-0252-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

This dispute was received on 08/27/02.

I. DISPUTE

Whether there should be additional reimbursement for hospital admission for dates of service 09/25/01 through 09/30/01. Carrier denied services as, "Y1200 (Room and board semi-pvt)–F-The charges for this hospitalization have been reduced based on the fee schedule allowance F-The charge for this procedure exceeds fair and reasonable."

II. RATIONALE

During the respondent's audit of the disputed services, the carrier improperly carved out the charges for the implantables, applied the per-diem (§134.401(c)(1)) and reimbursed the requestor a total of $97,465.60. Per Rule 134.401 (c)(4)(A)(i) this action is allowed only when stop loss is not in effect with a total audited bill below $40,000.00.

Audit reductions are made per Rule 133.1, 133.301 and 134.401. Per Rule 134.401 (c)(6)(v), "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed."

According to Rule 134.401 (b)(2)(A) all hospitals are required to bill usual and customary. The requestor billed usual and customary. The carrier's audit (EOBs) and response failed to prove the requestor's charges were not their usual and customary. Consequently, without the appropriate audits per §133.301 and 134.401, the total of these disputed/audited charges exceed $40,000.00.

According to Rule 134.401(c)(6), the services in dispute are to be reimbursed per the Stop-Loss Method. Stop-loss is an independent methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. Rule 134.401(c)(6)(A)(i) states that to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000. The reimbursement for the entire audited admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%. The Stop-Loss Reimbursement Factor is multiplied by the total audited charges to determine the Workers Compensation Reimbursement Amount (WCRA) for the admission.

Rule 134 401(c)(6)(B) states the formula for calculating the appropriate reimbursement is:

Audited Charges x SLRF = WCRA."

$194,931.19	Total billed charges
0.00	Proper audit reductions
$194,931.19	Total audited charges
x 75%	SLRA
146,198.39	Total recommended reimbursement
-97,465.60	Payments made
$48,732.79	Additional reimbursement recommended (WCRA)

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Medical Review Division has determined that the requestor is entitled to additional reimbursement for hospital admission of 09/25/01 through 09/30/01. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$48,732.79** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 13th day of October 2004.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mkb

Allen McDonald, Director
Medical Dispute Resolution
Medical Review Division

AM/mkb

APPENDIX 17

TAB 17

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-4223.M4

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 9/30/02.

I. DISPUTE

Whether there should be additional reimbursement for hospital charges from 10/22/01 and extending through 10/25/01. The services were reduced on the basis of "F" – submitted services were re-priced in accordance with state per diem guidelines and "M" - Fair and Reasonable".

II. RATIONALE

During the respondent's audit of the disputed services, the carrier improperly carved out the charges for the implantables and reimbursed the requestor a total of $18,680.68. Per Rule 134.401 (c)(4)(A)(i) this action is allowed only when stop loss is not in effect with a total audited bill below $40,000.00.

Audit reductions are made per Rule 133.1, 133.301 and 134.401. Per Rule 134.401 (c)(6)(v), "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." The total of these disputed/audited charges exceed $40,000.00. The insurance carrier's response explained their audit was made according to a SOAH decision. The Commission's review of the insurance carrier audit revealed that Rule 134.401 was improperly applied to the disputed charges. There were no proper audit reductions per 133.1 or 133.301. The respondent used a SOAH decision as their method for reimbursement, which is not consistent with Commission rules.

According to Rule 134.401 (b)(2)(A) all hospitals are required to bill usual and customary. The requestor billed usual and customary. The carrier's audit (EOBs) and response failed to prove the requestor's charges were not their usual and customary inplantables and inpatient charges. The total of these disputed/audited charges exceed $40,000.00.

According to Rule 134.401(c)(6), "the services in dispute are to be reimbursed per the Stop-Loss Method. Stop-loss is an independent methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. Rule 134.401(c)(6)(A)(i) states that to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000.00. The reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%. The Stop-Loss Reimbursement Factor is multiplied by the total audited charges to determine the

Workers Compensation Reimbursement Amount (WCRA) for the admission. Audited charges are those charges, which remain after a bill review by the insurance carrier has been performed.

Rule 134.401(c)(6)(B) states the formula for calculating the appropriate reimbursement is:

Audited Charges x SLRF = WCRA.

Using the Stop-Loss methodology, the total allowable WCRA for the audited charges is $30,281.38 ($40,375.18 / total charges x 75%). The respondent paid $18,680.68 of the total charges. Additional reimbursement in the amount of $11,600.70 ($30,281.38/WCRA - $18,680.68/ paid) is recommended.

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement for hospital charges from 10/22/01 through 10/25/01 in the amount of **$11,600.70.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **$11,600.70** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 12th day of February 2004.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division

DRM/nlb

APPENDIX 18

TAB 18

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $28,018.15 for dates of service 01/05/02 and extending through 01/10/02

   b. The request was received on 08/01/02.

II. EXHIBITS

1 Requestor, Exhibit I:

   a. TWCC 60 and Position Statement on Table of Disputed Services
   b. UB-92
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/16/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/16/02. The response from the insurance carrier was received in the Division on 09/30/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services

"Claim should be paid at 75% of bill [sic] charges, without any provision for carve-out of implants."

2. Respondent: Letter dated 09/27/02:

"This dispute involves the Carrier's reduction in payment based on a per diem methodology versus stop-loss.... The requestor billed the carrier $66208.45 for this 5-day stay....'To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000 ...' Following the carrier's audit, the hospital bill amount was below $40,000. Therefore, the carrier reimbursed the requestor the $5590.00, based on a per diem rate of $1118.00 per day in addition to reimbursement in the amount of plus [sic] 6704.19 for implants at cost plus 10%. The carrier allowed reimbursement for Bak cages, screws, rods and connector clamps. Because the requestor failed to provide invoices for implants, the carrier based the cost of implants on its own data collected for similar services. The total initial payment was $12,294.19. Subsequently, the requestor provided invoice information for implants and the carrier reimbursed the requestor an additional $9344.00, bringing the total payment to $21,638.19. ... Payment to the requestor based on stop-loss methodology when the stop-loss threshold was bridged because of an unsubstantiated markup increase in surgical implants, for unknown reasons, is not fair to the carrier or the policy-holder, is not reasonable, and is inconsistent with effective medical cost control."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service (dos) eligible for review are those commencing on 01/05/02 and extending through 01/10/02.

2. The Provider billed the Carrier $66,208.45 for the dos in dispute.

3. The Carrier made a total reimbursement of $21,638.19 for dos in dispute.

4. The amount left in dispute is $28,018.15, per the table of disputed services.

5. The carrier denied the charges as, "DIEM-F—REIMBURSED IN ACCORDANCE WITH THE TEXAS HOSPITAL INPATIENT FEE GUIDELINE; COST- M- N- SERVICES WERE REIMBURSED IN ACCORDANCE WITH THE CARRIER'S FAIR AND REASONABLE, COST DATA IS UNAVAILABLE FOR YOUR FACILITY AT THIS TIME. ADDITIONAL REIMBURSEMENT MAY BE CONSIDERED UPON RECEIPT OF THIS INFORMATION; AND M-THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)."

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $66,208.45. Per Rule 134.401 (c)(6)(A)(i)(iii), once the audited bill has reached the minimum Stop-Loss threshold of

$40,000 00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone); those not related to the compensable injury; or if an onsite audit is performed, those charges not documented as rendered during the admission.

The carrier is allowed to audit the hospital bill on a per line basis. In reading Rule 134.401 (c)(4), additional reimbursement (for implantables or orthotics/prosthetics) **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "...usual and customary charges..." per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the cost of the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for the implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, since the rule states this method is used only for the per diem reimbursement methodology.) The carrier indicated that after their audit, the bill was below $40,000.00. The implantables were paid on an estimated amount based on data collected for similar services because there was no invoice submitted, along with the per diem amount for a surgical admission. An additional amount was paid upon receipt of the invoice for the implantables. There was no documentation submitted by the carrier to indicate that the reduction of the implantables was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the provider. Even if the charge appears to be inflated based on an invoice or based on information from the fee guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the facility challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology. There was no copy of the actual audit provided by the carrier in order to determine what had been subtracted from the bill based on Rule 134.401 (c) (6) (v).

Since the carrier has not submitted sufficient information to determine whether or not the hospital should have been paid at per diem or per the stop-loss methodology, the denial code of "M" for the implantables is a moot point. The reimbursement of the implantables at cost plus 10% would only be applicable if the per diem rate was the appropriate reimbursement method. The carrier has not supported their contention that the provider should be paid based on the per diem rate.

Therefore, the Medical Review Division, based on the available documentation, recommends payment in the amount of **$28,018.15**.

VI. ORDER

The above Findings and Decision are hereby issued this 04th day of April 2003.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division

CO/co

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby Orders the Respondent to remit $28,018.15 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

Judy Bruce
Director of Medical Review
Medical Dispute Resolution

JB/co

APPENDIX 19

TAB 19

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $12,696 19, for dates of service 09/21/01 through 09/25/01.

   b. The request was received on 08/28/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. UB-92
   c. Reimbursement data for implants
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 10/01/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 10/03/02. The response from the insurance carrier was received in the Division on 10/17/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 09/25/02

> "TWCC Rule 134.401 provides the rules regarding reimbursement for Acute Care In-patient Hospital Fee services. Specifically, reimbursement consists of 75% of remaining charges for the entire admission, after a Carrier audits a bill. See Tex. Admin. Code Section 133.401 (c). The Carrier is allowed to deduct any personal items and may only deduct non-documented services and items and services which are not related to the compensable injury. At that time, if the total audited charges *for the entire admission* are below $40,000, the Carrier may reimburse at a 'per diem' rate for the hospital services. However, if the total audited charges *for the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission.'... In accordance with the TWCC Rules and QRL 01-01, the total amount of reimbursement due the hospital is $66,920.52. This amount is derived from the formula presented in 133.401(c)(6)(B),(C). Specifically, the audited charges $(89,227.36)-deducted charges (none per the EOB) x .75 = ($66,920.52) The prior amounts paid by the carrier were $53,864.33. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of ($66,920.52-$54,224.33)=**$12,696.19, plus interest.**"

2. Respondent: Letter dated 10/16/02

> "We maintain that the billed charges of $89,227.36 are excessive, and do not represent usual and customary for the services rendered. We have also enclosed copies of two bills with their respective implant invoices, for other injured workers. It appears that this provider routinely overcharges for implants up to 300-400% of cost. The guidelines, as well as the letter from TWCC included by the requestor, clearly state that payment should be 75% of usual and customary, not 75% of billed charges. To document this, we have also enclosed two bills for similar injuries from providers within the same general zip code. We reviewed the length of stay, principal diagnosis codes, and total charges. In light of this review, we feel that the reimbursement to (Provider) of $57,444.27 represents a 75% of the usual and customary charges for these services."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 09/21/01 through 09/25/01.

2. The Provider billed the Carrier $89,227.36 for the dates of service 09/21/01 through 09/25/01.

3. The Carrier made a total reimbursement of $54,224.33 for the dates of service 09/21/01 through 09/25/01.

4. The amount left in dispute is $12,696.19.

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $89,227.36. Per Rule 134.401 (c)(6)(A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone), not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission.
The carrier is allowed to audit the hospital bill on a per line basis. Per the EOB, the Carrier paid $5,486.25 for supply/implants. The Carrier denied "Hospital Services" with the denial code of "N-NOT DOCUMENTED NURSE REVIEW **PLEASE SUBMIT WITH THE COST INVOICE FOR THE IMPLANTS." In reading Rule 134.401 (c)(6), additional reimbursement **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, " ...usual and customary charges..." per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, since the rule states this method is used only for the per diem reimbursement methodology.) There was documentation submitted by the carrier to indicate that the reduction of the implantables was based on reviewing other hospital bills in the general vicinity of the Requestor. The carrier submitted 2 additional UB-92's from another facility based in the Houston area. On one UB-92, the charge for 3 units of "implants" was $17,022.00. On the other UB-92, the charge for 29 units of "implants" was $18,250.00. However, the carrier failed to supply the actual invoices for the additional UB-92's in order for the Division to determine what the "usual and customary" mark-up for implants is.

The carrier would also subtract any personal items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

The hospital has billed its "usual and customary charge" of $19,950.00 for the implantables. The carrier has not submitted enough evidence of what is usual and customary in that region for these items.

Therefore, the total reimbursement will be calculated in the following manner:

Total charges are $89,227.36 as listed on the disputed table.
The Provider has stated in their position statement the total charges are $89,227.36
The total charges on the EOBs are $89,227.36.
The carrier paid $54,224.33 as listed on the disputed table.
According to the copies of the checks the total payment by the Carrier is $54,224.33.
Multiply the audited charges of $89,227.36 x 75%
$89,227.36 x .75= $66,920.52
$66,920.52 - $54,224.33 = $12,696.19
Therefore, additional reimbursement is recommended in the amount of **$12,696.19**.

The above Findings and Decision are hereby issued this 21st day of November 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $12,696.19 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 21st day of November 2002

David R. Martinez
Manager Medical Dispute Resolution
Medical Review Division

DM/mb