SOAH Docket No. 454-23-24074 **Suffix: M4_NP**

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

CRESCENT REGIONAL HOSPITAL,
PETITIONER
V.
HARTFORD CASUALTY INSURANCE COMPANY,
RESPONDENT

DECISION AND ORDER

Petitioner Crescent Regional Hospital (Provider) challenges the decision of the Texas Department of Insurance, Division of Workers' Compensation (Division), which denied Provider's claim for reimbursement from Hartford Casualty Insurance Company (Carrier) for services provided to an injured worker (Patient). The Administrative Law Judge (ALJ) finds that Provider demonstrated that the services provided were preauthorized and reimbursable. Therefore, the ALJ concludes that Provider is entitled to reimbursement in the amount of $106,585.56.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

There are no contested issues of notice or jurisdiction; therefore, these matters are addressed solely in the Findings of Fact and Conclusions of Law.

On October 5, 2022, the Division received Provider's request for a Medical Fee Dispute Resolution (MFDR).[1] On October 24, 2022, Carrier filed a response to the MFDR request, arguing that Provider's preauthorization was valid only through July 24, 2022, but Provider kept him inpatient for longer than was approved.[2] On April 27, 2023, the Division issued its MFDR decision and concluded that Provider was not entitled to the reimbursement sought.[3] Provider requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination. On July 24, 2023, the Division issued a Request to Docket letter that, when combined with the ALJ's order setting the hearing, issued August 17, 2023, served as a notice of hearing.

On October 17, 2023, SOAH ALJ Brent McCabe convened a hearing on the merits via Zoom videoconference. Provider appeared through its attorney, Kim C. Smith. Carrier appeared through its attorney, Jason T. Musick. The record closed the same day with the filing of the admitted exhibits.

---

[1] *See* Provider Ex. C-3; Carrier Ex. K at 2.

[2] Provider Ex. C-4 at 1.

[3] Carrier Ex. K at 3.

II. APPLICABLE LAW

This case involves a medical fee dispute for reimbursement under a workers' compensation policy provided by Carrier. The resolution of a fee dispute is regulated by the Division's billing, audit, and payment rules.[4]

An insurance carrier is liable for all reasonable and necessary medical costs of certain health care only when the services have been preauthorized prior to providing the health care, or when concurrent utilization review[5] was approved prior to providing an extension of certain preauthorized health care.[6] Inpatient hospital stays[7] and spinal surgery require preauthorization.[8] An extension to a patient's inpatient length of stay beyond the approved time for treatment requires concurrent utilization review.[9] A carrier's approval shall state, among other things, the specific health care and the period of time to complete the treatments.[10] A provider must request concurrent utilization review prior to the conclusion of that specified period of time

[4] 28 Tex. Admin. Code chs. 133-34.

[5] Concurrent utilization review is a form of utilization review for certain on-going health care extending beyond an original preauthorization. 28 Tex. Admin. Code § 134.600(a)(3).

[6] 28 Tex. Admin. Code § 134.600(c)(1)(B), (C); *see also* Tex. Labor Code § 413.014 (authorizing the Division to adopt rules regarding preauthorization).

[7] An inpatient hospital stay includes both the principal scheduled procedure(s) and the length of stay. 28 Tex. Admin. Code § 134.600(p)(1).

[8] 28 Tex. Admin. Code § 134.600(p)(1), (3).

[9] 28 Tex. Admin. Code § 134.600(q)(1).

[10] 28 Tex. Admin. Code § 134.600(l).

and must receive approval prior to extending a previously approved inpatient length of stay.[11]

If a health care provider is denied or paid a reduced amount for the medical services rendered to an injured employee, the provider is entitled to review—MFDR—by the Division.[12] If a dispute remains after an MFDR review, a party may request a contested case hearing at SOAH.[13] As the party requesting a hearing at SOAH to challenge an adverse medical fee dispute decision, Provider has the burden of proof to show by a preponderance of the evidence that Provider is entitled to reimbursement.[14] The hearing before SOAH is a de novo review of the issues involved.[15]

[11] 28 Tex. Admin. Code § 134.600(c)(1)(C), (f), (q)(1).

[12] Tex. Labor Code § 413.031(a).

[13] Tex. Labor Code § 413.0312(e).

[14] 28 Tex. Admin. Code § 148.14(b), (e).

[15] *See Vista Med. Ctr. Hosp. v. Tex. Mut. Ins. Co.*, 416 S.W.3d 11, 17-18 (Tex. App.—Austin 2013, no pet.).

III. EVIDENCE

At the hearing, Provider offered four exhibits[16] and Carrier offered 11 exhibits,[17] all of which were admitted. No testimony was offered.

Provider's MFDR request states that it seeks reimbursement of $106,585.56 for services from July 22–25, 2022, under codes "IP SURGERY DRG 454" and "IMPLANTS REV 0278."[18] The documents illustrate the following timeline:

- May 10, 2022 – Patient visited Dr. Stephen Neece, who concluded that the patient needed a transforaminal lumbar interbody fusion (TLIF) at two levels for canal and foraminal decompression and an instrumented stabilization from L2 to L4.[19] In a worker's compensation status report dated the same day, Dr. Neece identified the injury as a lumbar injury and that Patient was disabled from that date until recovery from surgery.[20]
- May 24, 2022 – Carrier authorized the requested service of L2-4 TLIF (CPT code 22558) with an expiration date of July 24, 2022 (authorization no. 5476365).[21]
- May 26, 2022 – Carrier issued another authorization under the same number for the L2-4 TLIF service (CPT codes 22633, 22634, 22214,

[16] Provider Exs. C-1 to C-4.

[17] Carrier Exs. A-K.

[18] Provider Ex. C-3 at 1.

[19] Provider Ex. C-3 at 12, 20.

[20] Provider Ex. C-3 at 22.

[21] Carrier Ex. A at 1.

22216, 53267, 22842, 22853, 20931, 20930, 20939).[22] This authorization also expired on July 24, 2022.

- June 1, 2022 – A surgery scheduling request form under the same preauthorization number was submitted that indicated that the surgery would be inpatient, with a procedure date of July 22, 2022. The form identifies the procedure as an "TLIF L2-L4" with diagnosis code M51.26 and various CPT codes.[23]

- July 22, 2022 – Patient was admitted with Provider and underwent a spinal surgery to the L2-L4 vertebrae.[24]

- July 24, 2022 – Provider completed a progress note that patient was doing well, had controlled pain, and was requesting discharge home.[25]

- July 25, 2022 – Patient was discharged.[26]

- August 30, 2022 – Provider submitted a claim for reimbursement with Carrier.[27]

- September 16, 2022 – Carrier, in reviewing the submitted claim for reimbursement, denied the request, stating that they were non-covered charges and "reimbursement is being withheld as the treating doctor and/or services rendered were not approved based on handler review."[28] The explanation of benefits (EOB) identifies Patient's admission date as

[22] Carrier Ex. B at 1.

[23] Provider Ex. C-3 at 54.

[24] Provider Ex. C-3 at 41.

[25] Provider Ex. C-3 at 45.

[26] Provider Ex. C-3 at 52.

[27] *See* Provider Ex. C-3 at 26.

[28] Provider Ex. C-3 at 26.

July 22, 2022, with a discharge date of July 25, 2022.[29] The date of service for each service listed in the EOB is July 22, 2022.[30]

- September 27, 2022 – Carrier, on reevaluation of the claim, upheld the denial of the claim for the same reasons.[31]

- October 3-5, 2022 – Representatives of Provider (Jennifer Santos) and Carrier (Sharon Taylor) exchanged emails about the claim. In the email, Ms. Santos inquires about the basis for Carrier's denial.[32] In her original response, Ms. Taylor states that the denial was because the authorization expired on July 24 and was only a two-day stay, and Provider exceeded the authorization by discharging Patient on July 25.[33] Ms. Santos responds that the authorization does not state that it was limited to two days and the reimbursement would not change based on days because it is a flat rate paid by the DRG code.[34] Ms. Taylor replies that the authorization would have provided the number of inpatient days if it were approved for inpatient and then concludes that no inpatient days were approved.[35]

- October 5, 2022 – Provider submitted a Retrospective Pre-authorization Request, to which Ms. Taylor states that there is no provision for retroactive authorization under Texas law.[36] In its letter requesting retroactive authorization, Provider notes that the authorized CPT codes included a code that was only inpatient.[37] Ms. Santos also indicates that the

[29] Provider Ex. C-3 at 26.

[30] Provider Ex. C-3 at 26-27.

[31] Provider Ex. C-3 at 28-29.

[32] Provider Ex. C-3 at 55-56.

[33] Provider Ex. C-3 at 57.

[34] Provider Ex. C-3 at 58.

[35] Provider Ex. C-3 at 59-60.

[36] Carrier Ex. E at 1; Provider Ex. C-3 at 65.

[37] Carrier Ex. H at 1.

doctor's office that requested authorization specified that the request was for inpatient services.[38]

Provider submitted an August 25, 2022 invoice totalling $615,499.64, identifying July 22, 2022, as the date of admission, the principal procedure, and the other procedures.[39] In this invoice, the line item for supply and implants totals $288,550.00 of the total bill.[40] The itemized list of charges likewise stated a service date of either July 22 or was blank.[41] The bills also included an invoice, dated July 22, 2022, from Tritin Medical Distribution, LLC to Crescent Medical Center, which detailed the cost of certain implants and accessories[42] and a purchase order request for neuromonitoring tools, dated July 22.[43]

As part of its MFDR request, Provider also submitted a printout from Optum, which listed the Medicare compensation amounts for certain CPT and DRG codes.[44] Specifically, Provider's printout identified a total Medicare reimbursement amount of $39,911.63 for the DRG 454 (inpatient) code.[45] For the CPT 22633 (outpatient)

[38] Carrier Ex. H at 2.

[39] Provider Ex. C-3 at 31.

[40] Provider Ex. C-3 at 31.

[41] Provider Ex. C-3 at 32-37. The itemized statement also included an accounts receivable, or AR, date for each charge between July 22 to August 1. Provider Ex. C-3 at 32-37.

[42] Provider Ex. C-3 at 38.

[43] Provided Ex. C-3 at 39.

[44] Provider Ex. C-3 at 24-25.

[45] Provider Ex. C-3 at 24.

code, the Optum printout listed a Medicare reimbursement amount of $12,393.80 and a patient copay of $2,478.76.[46]

In April 2023, the Division issued its MFDR decision that the Carrier's denial of reimbursement was upheld because it concluded that the services ended on July 25, 2022, the preauthorization expired on July 24, 2022, and no concurrent review was submitted for the extension of Patient's length of stay.[47]

IV. ANALYSIS

The case turns on the preauthorization received by Provider and the effect, if any, of failing to seek concurrent review. It is undisputed that Provider received preauthorization for the TLIF spinal procedure, which gave a deadline of July 24, 2022, to perform the authorized treatment. The procedure was performed on July 22, with Patient remaining inpatient until discharged on July 25. Provider did not request concurrent review or an extension of time for Patient to remain inpatient.

Provider argues that the extra day does not affect the claim for reimbursement amount. Carrier argues that the Division rules required Provider to seek concurrent review for inpatient health care if extending beyond the deadline for treatment in the original preauthorization. Carrier asserts that the evidence is insufficient to allow costs incurred before the July 24 cutoff to be segregated from those incurred on July

[46] Provider Ex. C-3 at 25.

[47] Carrier Ex. K at 4.

25 and, therefore, Provider is not entitled to any reimbursement. Provider carries the burden in this proceeding. The ALJ finds that Provider has met its burden.

First, Provider received preauthorization for the services performed. While the documents reflect some dispute over whether inpatient days were approved, the evidence establishes Carrier approved the procedure with at least one of the codes being an inpatient-only code. The scheduling request form, while sent after the preauthorization, reaffirms the parties' understanding that the procedure would be inpatient. Additionally, Carrier itself seemed unsure of the scope of its authorization, initially stating that it was for two days and then asserting that it was only for outpatient care. While Carrier's authorization fails to clearly define the number of inpatient days, the evidence establishes that Provider received authorization for a procedure that required an inpatient stay, and the authorization was valid through July 24, 2022.

Second, the fact that Patient was discharged on July 25, 2022, does not invalidate the preauthorization through July 24. The Division rules describing the carrier's liability for costs in the situation state the requirements in the disjunctive—either preauthorization *or* concurrent utilization review.[48] The rules also distinguish between inpatient hospital admission, which requires preauthorization, and inpatient length of stay, which is a subset of the inpatient hospital admission and would require concurrent utilization review.[49] Therefore, the question turns to what

[48] 28 Tex. Admin. Code § 134.600(c).

[49] 28 Tex. Admin. Code § 134.600(p)(1), (q)(1).

portions, if any, of the claim for reimbursement are tied to services provided for the length of stay on July 25. The evidence establishes the answer is none.

To begin, the reimbursement amount for the requested DRG code is a set amount. There is no daily reimbursement rate or outlier payment request for Patient's length of stay. Instead, the reimbursement requested is tied solely to the procedure performed, which was performed within the original preauthorization. This is reinforced by the service dates in Provider's billing and reimbursement documents. While Patient was discharged on July 25, 2022, and the MFDR request lists the disputed dates of service as July 22 through July 25, there is nothing in the billing records indicating that Provider actually sought reimbursement for services provided on July 25. Instead, the EOB and reevaluation EOB each list a service date of July 22 for all claimed services, and the itemized billing similarly provides a service date of only July 22 or none. While it may be reasonable to infer that Provider incurred charges for services on July 25, there is nothing in this record to conclude the reimbursement sought includes services on July 25 or is based on the extended length of stay.

Additionally, the reimbursement request for the cost of the implants used in the procedure is not tied to a length of stay, but to the principal procedure which was preauthorized and performed within the time specified in the authorization. Therefore, even if it were found that the evidence did not support reimbursement for the surgical services, the evidence establishes that Provider is entitled to reimbursement for the cost of the implants in the amount of $63,481.00.

The Division rules do not include the principal scheduled procedure in the services requiring concurrent review (as separately listed from length of stay). Here, Provider seeks reimbursement for that procedure without modification based on the length of stay, and Provider is entitled to reimbursement of its claim. Therefore, the ALJ finds that Provider has met its burden to establish that it provided services that were preauthorized by Carrier and is entitled to reimbursement in the amount of $106,585.56.[50]

V. FINDINGS OF FACT

1. On May 24 and 26, 2022, Hartford Casualty Insurance Co. (Carrier) approved authorization to Crescent Regional Hospital (Provider) to provide the following service to an injured worker (Patient) between the dates of May 24 and July 24, 2022: L2-4 TLIF, an inpatient spinal surgery.

2. On July 22, 2022, Patient was admitted with Provider for the authorized procedure. Patient was discharged on July 25, 2022.

3. The L2-4 TLIF procedure was performed on July 22, 2022, within the time required by Carrier's preauthorization.

4. Provider incurred charges of $326,949.64 for the surgery under DRG code 454 and $288,550 for the cost of the implants under implant revenue code 0278.

5. The cost for the implantables was incurred on July 22, 2022, at the time of the surgery.

6. The services billed contain a service date of July 22, 2022.

7. No service billed has a service date of July 25, 2022.

[50] This amount consists of $43,104.56 under DRG code 454 and $63,481.00 under implant revenue code 0278.

8. The reimbursement sought by Provider is a flat fee reimbursement based on the procedure performed.

9. Provider is not seeking reimbursement based on the length of stay on July 25, 2022.

10. The sum of the Medicare facility specific reimbursement amount for DRG code 454 is $39,911.63.

11. The maximum allowable reimbursement amount, with a separate reimbursement request for implants, for DRG code 454 is $43,104.56.

12. The reimbursable amount for the implantables is $63,481.00.

13. Provider incurred reimbursable costs in the amount of $106,585.56.

14. In August 2022, Carrier received a reimbursement request from Provider for these health care services, stating charges totaling $615,499.64 with a service date of July 22, 2022.

15. In September 2022, Carrier denied reimbursement and sent Provider an explanation of benefits form for the claim, indicating that the services rendered were not approved. Later that month, Carrier denied Provider's request for reimbursement on reevaluation for the same reason.

16. On October 5, 2022, the Texas Department of Insurance, Division of Workers' Compensation (Division) received Provider's request for a Medical Fee Dispute Resolution (MFDR), in which it requested reimbursement in the amount of $106,585.56.

17. On October 24, 2022, Carrier filed a response to the MFDR request, arguing that the preauthorization was valid only through July 24, 2022, but Provider kept Patient inpatient for longer than was approved.

18. On April 27, 2023, the Division issued its MFDR decision, finding that Provider was not entitled to the reimbursement sought.

19. Provider timely requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination.

20. On July 24, 2023, the Division issued a notice to the parties with a statement of the nature of the hearing; 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 either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

21. On August 17, 2023, the SOAH Administrative Law Judge (ALJ) issued an order stating the time and place of the hearing and instructions for participating in the hearing.

22. On October 17, 2023, SOAH ALJ Brent McCabe convened a hearing on the merits via Zoom videoconference. Provider appeared through attorney Kim C. Smith. Carrier appeared through attorney Jason T. Musick. The record closed the same day with the filing of exhibits.

VI. CONCLUSIONS OF LAW

1. Adequate and timely notice of the hearing was provided to the parties. Tex. Gov't Code §§ 2001.051-.052.

2. If a health care provider is denied or paid a reduced amount for the medical services rendered to an injured employee, the provider is entitled to review—an MFDR—by the Division. Tex. Labor Code § 413.031(a).

3. If a dispute remains after the MFDR review, a party may request a contested case hearing at SOAH. Tex. Labor Code § 413.0312(e).

4. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. Tex. Labor Code §§ 413.031, .0312(e); Tex. Gov't Code ch. 2003.

5. The hearing before SOAH is a de novo review of the issues involved. *See Vista Med. Ctr. Hosp. v. Texas Mut. Ins. Co.*, 416 S.W.3d 11, 17-18 (Tex. App.—Austin 2013, no pet.).

6. Provider has the burden of proof to show by a preponderance of the evidence that it is entitled to reimbursement. 28 Tex. Admin. Code § 148.14(b), (e).

7. An insurance carrier is liable for all reasonable and necessary medical costs relating to health care only when a preauthorization of certain health care was approved prior to providing the health care or concurrent utilization review of certain health care was approved prior to providing the health care. 28 Tex. Admin. Code § 134.600(c)(1)(B), (C); *see* Tex. Labor Code § 413.014(b), (c).

8. Health care services requiring preauthorization include inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay, and spinal surgery. 28 Tex. Admin. Code § 134.600(p)(1), (3).

9. Health care services requiring concurrent utilization review include inpatient length of stay extending beyond the preauthorized period of time, but do not include principal scheduled procedure(s) or spinal surgery. 28 Tex. Admin. Code § 134.600(f), (q)(1).

10. Provider sought reimbursement for services that were preauthorized. 28 Tex. Admin. Code § 134.600(c).

11. Provider is entitled to reimbursement in the amount of $106,585.56, plus any applicable interest.

VII. ORDER

It is **ORDERED** that Hartford Casualty Insurance Co. is required to pay the sum of $106,585.56, plus any applicable interest, to Crescent Regional Hospital for the services at issue in this case.

VIII. NONPREVAILING PARTY DETERMINATION

Texas Labor Code section 413.0312(g) and 28 Texas Administrative Code section 133.307(h) require the nonprevailing party to reimburse the Division for the cost of services provided by SOAH. Texas Labor Code section 413.0312(i) requires SOAH to identify the nonprevailing party and any costs for services provided by SOAH in its final decision. For purposes of Texas Labor Code section 413.0312,

Hartford Casualty Insurance Co. is the nonprevailing party. The costs associated with this decision are set forth in Attachment A to this Decision and Order and are incorporated herein for all purposes.

SIGNED DECEMBER 13, 2023.

ALJ Signature:

_____

Brent McCabe

Presiding Administrative Law Judge