STATE OFFICE OF ADMINISTRATIVE HEARINGS
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DOCKET NO. 453-03-0910.M4
[MDR TRACKING NO.. M4-02-2243-01]

ZURICH AMERICAN INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	**OF**
TEXAS WORKERS' COMPENSATION COMMISSION AND HEALTHSOUTH MEDICAL CENTER	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Zurich American Insurance Company ("the Carrier") has appealed the Findings and Decision issued by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission) in a fee dispute involving an interpretation of the Commission's hospital fee guideline. The decision ordered the Carrier to reimburse HealthSouth Medical Center ("the Hospital") an additional $29,342.36 by calculating the reimbursement using stop-loss methodology. The Carrier argued it correctly reimbursed the Hospital in the amount of $17,133.72, based on the per diem methodology contained in the guideline. The Administrative Law Judge (ALJ) finds the per diem methodology should be followed in this proceeding. Accordingly, this decision reverses the decision of the MRD and finds that no additional reimbursement is required.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

On February 12, 2003, ALJ Kerry D. Sullivan convened the hearing in Austin, Texas. Steven M. Tipton, attorney, represented the Carrier. H. Douglas Pruett represented the Hospital. The Commission did not participate in the hearing.[1] Notice and jurisdiction were not contested and will be addressed in the findings of fact and conclusions of law. Following the presentation of evidence, the record closed on February 12, 2003.

II. DISCUSSION

A. Factual Overview

[1] It did, however, file a lengthy statement of matters asserted in defense of the MRD decision.

Workers Compensation Claimant____ sustained a compensable workers' compensation injury on_____. On July 25, 2001, the Claimant was admitted to HealthSouth Medical Center in Dallas, Texas, where he had a spinal fusion at L4-L5 and L5-S1 with instrumentation. The Hospital submitted a bill to the Carrier for $61,968.11 for the four-day inpatient stay and surgical procedure. Based on the stop-loss reimbursement method contained in the Hospital Fee Guideline,[2] the Hospital requested reimbursement of 75% of this amount, or $46,476.08. Instead, the Carrier reimbursed the Hospital $17,133.72, calculated pursuant to the per diem and "Additional Reimbursement" provisions of the Guideline.

After the Hospital requested medical dispute resolution, MRD ordered the Carrier to pay an additional $29,342.36 based on the stop-loss provision of the Guideline. The Carrier timely requested a hearing.

The underlying facts are not in dispute. The Claimant was admitted to the Hospital for a four day stay where he underwent spinal surgery to fuse L4-L5 and L5-S1 with instrumentation. Of the Hospital's overall bill of $61,968.11, the Hospital charged $36,118.29 for several pieces of surgical hardware referred to as "implantables," for which the hospital had paid $11,510.65. Carrier witness Julie Shank provided uncontroverted testimony that the surgical operation went as planned, was not unusually long, and required the hospital to provide neither unusually extensive nor expensive services.

B. The Regulations

In 1992 and again in 1997, the Commission adopted a fee guideline for hospital charges under the authority of Section 413.011 of the Texas Workers' Compensation Act ("the Act"). The 1992 guideline was subsequently invalidated because of procedural irregularities in its adoption and was repealed in 1997. In the preamble, the Commission stated it was adopting the 1997 Guideline to balance the following statutory standards: (1) to ensure that injured workers receive quality health care reasonably required by the nature of their injury as and when needed; (2) to ensure that the fee guidelines are fair and reasonable; (3) to achieve effective medical cost control; (4) to ensure that the fee paid for a workers' compensation patient would not be in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living; and (5) to take into consideration increased security of payment under the Act.[3] The Commission expected the 1997 Guideline to reduce the number of disputes and decrease costs.

The Guideline is somewhat complicated and confusing in terms of assessing whether and how to apply the stop-loss and the per diem reimbursement methodologies. The most significant provisions are set out below for ease of reference.

Section 134.401(b)(1) of the Guideline defines relevant terms. These include

> Stop-Loss Payment–An independent method of payment for an unusually costly or lengthy stay; and Stop-Loss Threshold (SLT)–Threshold of total charges established by the Commission, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor by the total charges identifying that particular threshold.

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[2] 1997 Acute Care Inpatient Hospital Fee Guideline (the Guideline) adopted as 28 TEX. ADMIN. CODE § 134.401.

[3] 22 *Tex. Reg*. 6265 (1997).

Section 134.401(b) (2) (C), under the category of "General Information, states, "All charges submitted are subject to audit as described in Commission rules."

Section 134.401(c), entitled "Reimbursement," includes the following provisions:

(1) Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: . . . Surgical–$1,118. . .

(2) Method. All inpatient service provided by an acute care hospital for medical and/or surgical admissions will be reimbursed using a service related standard per diem amount.

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(C) Independent reimbursement is allowed on a case-by-case basis if the particular case exceed the stop-loss threshold as described in paragraph (6) of this subsection . . .

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(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. . .

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(6) Stop-Loss Method. Stop-Loss is an independent reimbursement methodology established to ensure fair and a 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. . . . .

(A) Explanation.

(i) To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold.

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

(iii) If audited charges exceed the stop-loss threshold, reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%.

(iv) The Stop-Loss Reimbursement Factor is multiplied by the total audited charges to determine the Workers' Compensation Reimbursement Amount (WCRA) for the admission.

(v) Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are personal items (e.g., telephone, television). If an on-site audit is performed, charges for services which are not documented as rendered during the admission may be deducted. Items and services which are not related to the compensable injury may be deducted. The formula to obtain audited charges is as follows: Total Charges - Deducted Charges = Audited Charges.

Pointing out that, pursuant to Section 134.401(b)(2)(C), all charges submitted are subject to audit as described in the Commission's rules, the Carrier also relies upon Section 133.301, which provides that a carrier shall retrospectively review all medical bills and pay for or deny payment in accordance with the Act, rules, and appropriate fee and treatment guidelines.

C. Analysis

Two prior SOAH decisions by the same ALJ have addressed the treatment of implantables in the context of the Commission's Stop-Loss rule.[4] In those decisions, the ALJ determined that, even under the stop-loss method, the Carrier could audit and reduce charges for implantables that exceeded the hospital's costs plus 10%. The ALJ in the present proceeding concurs with this result.

As noted in the previous decisions and in the parties' arguments in this proceeding, the Commission has not applied these rules in a consistent manner with respect to the appropriate reimbursement of implantables. Sometimes the costs of the implantables have been carved out prior to applying the Stop-Loss provisions. More recently, the Commission has not allowed these costs to be carved out. The ALJ also agrees with the conclusion in the previous SOAH decisions that the rule is ambiguous and somewhat difficult to reconcile with stated Commission policy. In particular, and as noted by the Commission in the Statement of Matters Asserted:

> Given that the preamble to the (Guideline) clearly rejects a percentage of billed charges as a method of determining payment,[5] why is the stop-loss provision based on total charges. How do "total charges" promote cost-containment?

The Commission answers this question in the Statement of Matters Asserted by attempting to define "total charges" as the amount billed minus any charges reduced by the Carrier in its bill

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[4] SOAH Docket No. 453-00-2092.M4 (April 24, 2001) and SOAH Docket No. 453-01-1612.M4 (September 6, 2001).

[5] *22 Tex. Reg.* at 6297.

review, including reduction of charges to the ususal and customary amount, as authorized by 28 TAC §134.401. The ALJ acknowledges that Commission's approach would apparently provide some measure of cost containment. In the ALJ's view, however, the term "total charges" cannot reasonably be redefined in the manner Staff suggests outside of a rule-making proceeding.

Aside from changing the plain meaning of the term "total charges," Staff's approach would also be in real tension with Section 134.401 (c)(6)(A)(v), which appears to specify a discrete set of charges that the Carrier may adjust under the stop-loss method of reimbursement. As the Hospital points out, Section 134.401(c)(6)(A)(5) is a subset of the more comprehensive bill review provisions authorized under Section 133.301. Section 134.401(c)(6)(A)(v) would thus be superfluous if the Carrier could reduce stop-loss bills in accordance with the broader review rights set out in Section 133.301. Additionally, because Section 134.401(c)(6)(A)(v) is more specific than Section 133.301 in terms of applying to stop-loss cases, it would violate at least two rules of regulatory construction to interpret these provisions in a way that would render the more specific provision meaningless.[6]

On the other hand, if Section 134.401(c)(6)(A)(v) were accepted as the exclusive list of auditable items for stop-loss cases, hospitals would effectively have the ability to determine their level of reimbursement simply by doing the math and pricing implantables at the desired level–a result that would not achieve effective medical cost control, as required by Section 413.011(d) of the Labor Code.

Given this state of the regulatory framework, any potential interpretation would be at least somewhat problematic. But an overall review of the regulations, read with regard for the pertinent policy objectives, leads the ALJ to conclude that reimbursement under the stop-loss provisions is not an automatic right that vests every time a bill tops $40,000. Instead, it appears that the per diem rate is the default and preferred method of reimbursement that should be employed unless the Hospital justifies use of the stop-loss method in a particular case.

[6] Constructions that would render part of the rule useless should be avoided, and specific provisions are given preference over general provisions. *See 67 Tex. Jur. 3rd* (Statutes) §§121, 123.

Section 134.401(c)(2) goes so far as to state that all inpatient services will be reimbursed using a per diem method. Plainly, this section does not mean exactly what it says or the stop-loss provisions would be meaningless. But that wording is some indication that the stop-loss method should be construed as an exception to the general rule requiring application of the per diem methodology. Additionally, stop-loss is to be "allowed on a case-by-case basis" if the $40,000 threshold is exceeded.[7] When this occurs, the hospital is "eligible" for stop-loss reimbursement.[8] These terms do not suggest an unqualified right (or obligation) to proceed under the stop-loss methodology. Instead, the decision must be made in the context of a particular case, and with an eye toward fulfilling the underlying goal of that methodology within the broader context of the workers' compensation regulatory scheme.[9]

Turning to the specific circumstances of the present case, the ALJ finds that the facts do not warrant use of the stop-loss reimbursement method in this particular proceeding. Use of that method is simply not necessary in order to fairly and reasonably compensate the hospital in this proceeding. The only reason the hospital is even eligible for consideration of stop-loss reimbursement is that it charged the Carrier $36,118.29 for implantables that cost it only $11,510.65–an unexplained and unsupported markup of 250% over the hospital's direct costs. In sharp contrast, a markup of only 10% would be allowed under the per diem reimbursement method.

The ALJ believes the approach adopted here is consistent with the purpose of the rule, which is intended to ensure fair and reasonable compensation to the hospital for unusually costly service rendered during treatment to an injured worker. Elsewhere, the rule states that the threshold was established to "ensure compensation for unusually extensive services required during an admission." Finally, the regulations must provide effective medical cost control pursuant to Section 413.011(d) of the Act. As noted above, the surgical operation went according to plan, was not unusually long, and required the hospital to provide neither unusually extensive nor expensive services.

Aside from making the most sense in terms of ensuring effective cost control, it appears that this case-by-case approach would also consistently be the most fair to the parties. Carrier witness Julie Shanks, a registered nurse and the Commission's former Director of Medical Review, testified that the automatic application of stop-loss when the $40,000 threshold is attained could be unfair to either the hospital or the Carrier. Of course she believed it was unfair to the Carrier in the present case, where the hospital marked up the price of implantables by 250%. She also identified a potential context in which application of the stop-loss method could be unfair to the hospital: in a straight-forward case in which a hospital charged its actual costs (or even cost plus 10%) for expensive implantables and incurred few additional expenses, the hospital would lose money if its bill were automatically cut by 25% in accordance with the stop-loss procedure.

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[7] 28 TAC § 134.401(c)(2)(C).

[8] 28 TAC § 134.401(c)(6)(A)(i).

[9] The ALJ acknowledges that Section 134.401(c)(6)(A)(iii) and (iv) are couched in terms suggesting the automatic application of the stop-loss rule when the threshold is met. It is possible, however, to interpret these provisions as descriptive of the methodology *once it is determined* that stop-loss should be applied based on the factors described in the subsections that precede them. As noted above, the entire rule is unclear. The best the ALJ can hope to do is apply an interpretation that is reasonable and complies with the overarching purposes of the regulatory framework.

III. CONCLUSION

Under these circumstances, the ALJ finds that the Carrier appropriately applied the per diem methodology in reimbursing the Hospital $17,133.72 for the services in dispute. The MRD decision requiring the Carrier to reimburse the hospital an additional $29,342.36 based on the stop-loss methodology should be reversed, and no additional reimbursement should be required.

IV. FINDINGS OF FACT

1. Workers' Compensation claimant ____ ("the Claimant") sustained a compensable workers' compensation injury on_____.

2. At the time of the compensable injury, Zurich American Insurance Company ("the Carrier") was responsible for the Claimant's workers' compensation insurance coverage.

3. On July 25, 2001, the Claimant was admitted to HealthSouth Medical Center ("the Hospital") in Dallas, Texas.

4. The Hospital submitted an itemized bill to the Carrier for $61,968.11 for the Claimant's inpatient stay.

5. The Carrier reimbursed the Hospital a total of $17,133.72.

6. The Hospital requested dispute resolution services from the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission).

7. On August 26, 2002, MRD issued Findings and a Decision ordering the Carrier to remit an additional $29,342.36 to the Hospital based on the stop-loss methodology of the Acute Care Inpatient Hospital Fee Guideline (the Guideline) issued by the Commission in 1997.

8. On September 16, 2002, the Carrier filed a request for a hearing on MRD's decision.

9. The Commission sent notice of the hearing to the parties on November 1, 2002, and a statement of matters asserted on December 9, 2002. The notices informed the parties of the matter to be determined, the right to appear and be represented by counsel, the time and place of the hearing, and the statutes and rules involved.

10. The Claimant had a spinal fusion at L4-L5 and L5-S1 with an implant. The implant included certain hardware referred to as "implantables."

11. The Claimant was hospitalized for four days.

12. The surgery and the Claimant's hospital stay went well. It was not unusually lengthy, and there were no unusually extensive or expensive services provided by the hospital.

13. The Carrier reviewed the bill submitted by the Hospital.

14. The Carrier calculated the reimbursement on the per diem methodology of the Guideline.

15. The Carrier reimbursed the Hospital $4,472 for four days of inpatient care at the per diem rate of $1,118.

16. The Hospital purchased the implantables from vendors for $11,510.65.

17. The Hospital submitted a charge of $36,118.29 to the Carrier for the implantables.

18. The Carrier reduced the amount of reimbursement for the implantables to the cost of the implantables plus 10 percent and reimbursed the hospital this additional amount ($12,661.72).

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 The Carrier 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 The Carrier 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)(2), all inpatient services provided by an acute care hospital for a surgical admission will be reimbursed using a standard per diem amount.

7. Although the hospital's charges were eligible for consideration for payment according to the stop-loss method set out in 28 TAC §134.401, stop-loss should not be allowed in this case because there were no unusually extensive or expensive services provided in association with the Claimant's stay and the charges met the $40,000 threshold only because the Hospital marked up its charges for implantables by $24,607.64 above their cost.

8. The standard per diem amount for a surgical admission is $1,118, as set forth in 28 TAC § 134.401(c)(1).

9. As specified in 28 TAC § 134.401(c)(3), the formula for calculating reimbursement using per diem methodology is as follows:

> Length of Stay x Standard Per Diem Amount = the Workers' Compensation Reimbursement Amount.

10. Based on cost to the hospital plus 10 percent, an additional reimbursement of $12,661.72 shall be provided to the per diem for medically necessary implantables, according to 28 TAC §§ 134.401(b)(2)(B) and (c)(4)(A).

11. By applying the formula specified in Conclusion of Law No. 9 and adding the additional reimbursement, as specified in Conclusion of Law No. 10, the Hospital's appropriate reimbursement is $17,133.72.

12. As specified in Finding of Fact No. 5, the Carrier has already reimbursed the Hospital $17,133.72.

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

ORDER

It is hereby ordered that the appeal of HealthSouth Medical Center is denied.

SIGNED this 10th day of April, 2003.

KERRY D. SULLIVAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS