STATE OFFICE OF ADMINISTRATIVE HEARINGS
300 West 15th Street, Ste. 502
Austin, TX 78701

DOCKET NO. 453-03-1626.M4
TWCC DOCKET NO. M4-02-2454-01

NATIONAL AMERICAN INSURANCE COMPANY, *Petitioner*	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
METROPOLITAN METHODIST HOSPITAL and TEXAS WORKERS' COMPENSATION COMMISSION, *Respondents*	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

National American Insurance Company (Carrier or Petitioner) appealed the decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD) ordering reimbursement to Metropolitan Methodist Hospital (Hospital) for a hospital stay provided to Claimant. The decision ordered the Carrier to reimburse the Hospital an additional $15,878.30 by calculating the reimbursement using stop-loss methodology. The Carrier argued it correctly reimbursed the Hospital in the amount of $16,660.40 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, but that the Carrier improperly calculated the per diem rate. Accordingly, this decision finds that Carrier should reimburse the Hospital an additional $2,251.00, plus interest.

I. Jurisdiction, Notice, and Procedural History

The issues of jurisdiction and notice were not contested. Therefore, those matters are addressed in the findings of fact and conclusions of law without further discussion.

The MRD issued its decision August 16, 2002. Petitioner filed a timely request for hearing on September 5, 2002. Proper and timely notice of the hearing was issued January 10, 2003. The hearing convened and concluded on April 30, 2003, with the undersigned Administrative Law Judge (ALJ) presiding.[1] The record closed on May 6, 2003, to enable the parties to provide post-hearing briefing. Mahon Garry, attorney, represented Petitioner. Scott Placek, attorney, represented Respondent.

[1] The ALJ wishes to thank the parties for their preparation, including their submission of a joint stipulation of facts, and agreement to the admissibility of exhibits. The ALJ further wishes to thank the parties for excellent post-hearing briefing.

II. Discussion

1. Factual Overview

The underlying facts are not in dispute. Workers' Compensation Claimant___ sustained a compensable workers' compensation injury on___. On May 21, 2001, the Claimant was admitted to the Hospital in San Antonio, Texas, where he had a spinal fusion at L3-4 and L4-L5 with cages and autologous bone graft. He was released from the Hospital on May 26, 2003. The Hospital submitted a bill to the Carrier for $43,384.93 for the six-day inpatient stay and surgical procedure. Of the Hospital's overall bill, the Hospital charged $22,744.00 for several pieces of surgical hardware referred to as "implantables," for which the hospital had paid $11,094.00. Based on the stop-loss reimbursement method contained in the Hospital Fee Guideline,[2] the Hospital requested reimbursement of 75% of this amount, or $32,538.70. Instead, the Carrier reimbursed the Hospital $16,660.40, 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 $15,878.30, plus interest based on the stop-loss provision of the Guideline. The Carrier timely requested a hearing.

2. The Regulations

The dispute in this case centers on whether the stop-loss or the per diem reimbursement methodology should be applied. The rules that apply to the reimbursement methodology are contained in the 1997 Acute Care Hospital Fee Guideline (Guideline).

In the preamble to the Guideline, the Commission stated it was adopting the 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 attached to this Decision for ease of reference.

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

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

3. Analysis

In this case, Carrier first audited the bill based on what Carrier analyzed were the usual and customary charges for the area. After the audit, the bill was below $40,000.00. Then Carrier adjusted the charges for the implantables to actual cost plus ten percent. The Hospital argued that the Carrier's audit was inappropriate because it looked at facilities in areas of Texas other than San Antonio, and as far away as Harlingen and Sherman. The ALJ finds that the validity of Carrier's audit needs to be addressed in this case. Based on the legal standards discussed above, and the analysis below, the cost of the implantables should have been reduced to actual cost plus ten percent. Following that reduction, the total bill would be lower than $40,000.00 and the per diem reimbursement rate would apply.

Three prior SOAH decisions have addressed the treatment of implantables in the context of the Commission's stop-loss rule.[4] In those decisions, the ALJs 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, 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.

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 $40,000.00. 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.

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

[4] SOAH Docket No. 453-03-0910.M4 (April 10, 2003), SOAH Docket No. 453-00-2092.M4 (April 24, 2001), and SOAH Docket No. 453-01-1612.M4 (September 6, 2001).

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.[5] When this occurs, the hospital is "eligible" for stop-loss reimbursement.[6] 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.[7]

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. There was no evidence that Claimant's hospital stay and procedure were unusually long or complicated. Use of the stop-loss 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 $22,744.00 for implantables that cost it only $11,094.00 – an unsupported markup of over 200 percent of the Hospital's direct costs.[8] In sharp contrast, a markup of only ten percent 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. With the implantables reduced to $12,203.40 (cost plus ten percent), the total bill is $32,844.33, below the stop-loss threshold. Claimant was in the hospital for 6 days. Six days at the per diem of $1,118.00 totals $6,708.00, plus the implantables equals $18,911.40. Carrier paid $16,660.40. Therefore, additional reimbursement should be paid in the amount of $2,251.00, plus interest.

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[5] 28 TEX. ADMIN. CODE § 134.401(c)(2)(C).

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

[7] 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.

[8] Kimberly Brown, from HCA Health Care Services, the Hospital's owner, testified that an algorithm is used by the hospital to calculate the billed cost of certain items. She testified that as the cost of the item increases, the percentage mark-up of the item decreases. Her testimony did not explain how a mark-up of 200 percent would be fair and reasonable reimbursement in this case.

III. Conclusion

Under these circumstances, the ALJ finds that the per diem methodology is the appropriate methodology to apply in reimbursing the Hospital. Because the calculation of the per diem rate was incorrect, additional reimbursement should be made in the amount of $2,251.00, plus interest.

IV. Findings of Fact

1. On___, Claimant, ___ was an employee of___.

2. On___, ___provided workers' compensation insurance through National American Insurance Company (Carrier).

3. On___, Claimant sustained a compensable injury in the course and scope of his employment with ___ that was covered by Carrier.

4. From May 21, 2001 through May 26, 2001, Metropolitan Methodist Hospital (Hospital) provided medical treatment for Claimant's workers' compensation injury.

5. Claimant underwent a posterior interbody fusion at L3-4 and L4-5 with cages and autologous bone graft.

6. The Hospital submitted itemized billing totaling $43,384.93 to Carrier for the services provided to Claimant.

7. Part of the $43,384.93 charges was $22,744.00 for implantables used in Claimant's treatment.

8. The Hospital's actual cost for the implantables was $11,094.00.

9. On June 25, 2001, Carrier issued a payment of $16,660.40 to the Hospital for services provided after reducing the bill following an audit and applying the per diem methodology of the Acute Care Inpatient Hospital Fee Guideline (Guideline) issued by the Commission in 1997, which included the cost plus 10 percent of the implantables.

10. The Hospital requested dispute resolution services from the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) on February 22, 2002.

11. On August 16, 2002, MRD issued Findings and a Decision ordering Carrier to remit an additional $15,878.30 plus interest to the Hospital based on the stop-loss methodology of the Guideline.

12. On September 5, 2002, Carrier filed a timely request for a hearing on the MRD's decision.

13. All parties were provided adequate notice of the hearing on January 10, 2003. All parties appeared and participated in the hearing.

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 this proceeding, including the authority to issue a decision and order, pursuant to § 413.031(d) of the Act and TEX. GOVT. CODE ANN. ch. 2003.

3. The Petitioner timely filed notice of appeal, as specified in 28 TEX. ADMIN. CODE §148.3.

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

5. As the party appealing the MRD decision, the Petitioner has the burden of proof in this matter, pursuant to 28 TEX. ADMIN. CODE § 148.21(h).

6. As specified in 28 TEX. ADMIN. CODE § 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 TEX. ADMIN. CODE §134.401, stop-loss should not be allowed in this case because the charges met the $40,000 threshold only because the Hospital marked up its charges for implantables over 200 percent above their cost.

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

9. As specified in 28 TEX. ADMIN. CODE § 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 $12,203.40 shall be provided to the per diem for medically necessary implantables, according to 28 TEX. ADMIN. CODE §§ 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 $18,911.40.

12. The Carrier has already reimbursed the Hospital $16,660.40.

13. Based on the foregoing findings of fact and conclusions of law, the Carrier owes the Hospital an additional $2,251.00, plus interest.

ORDER

IT IS ORDERED THAT National American Insurance Company shall reimburse Metropolitan Methodist Hospital $2,251.00, plus interest.

Signed this 20th day of May, 2003

STATE OFFICE OF ADMINISTRATIVE HEARINGS

_____

WENDY K. L. HARVEL
ADMINISTRATIVE LAW JUDGE

ATTACHMENT

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.
>
> 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.
>
> ****
>
> (C) 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 this subsection . . .
>
> ****
>
> (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. . .
>
> ****
>
> (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 that 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.