SOAH DOCKET NO. 453-03-1628.M4
MDR TRACKING NO. M4-02-2664-01

HARLANDALE INDEPENDENT SCHOOL DISTRICT,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
VS.	§	**OF**
	§	
METHODIST SPECIALTY & TRANSPLANT HOSPITAL	§	
Respondent.	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Harlandale Independent School District (Carrier)[1] appealed the decision of the Texas Workers' Compensation Commission's (the Commission) Medical Review Division (MRD) ordering additional reimbursement of $7,675.70, plus interest, to Methodist Specialty & Transplant Hospital (Provider). In this decision, the Administrative Law Judge (ALJ) finds that Carrier met its burden of proving the reimbursement methodology utilized in this case was correct. Therefore, Carrier is not ordered to provide additional reimbursement to Provider. Furthermore, Provider is ordered to refund Carrier $6,041.41 it remitted to Provider as supplemental reimbursement.

The hearing convened on April 27, 2003, before Steven M. Rivas, ALJ. The record remained open until May 5, 2003, to allow the parties an opportunity to submit briefs and additional arguments. Carrier was represented by LeeAnna G. Mask, attorney. Provider was represented by R. Scott Placek, attorney.

I. DISCUSSION

1. Undisputed Facts[2]

Claimant ___ was an employee of Harlandale Independent School District and sustained a compensable injury on ___. As part of her treatment, Claimant was hospitalized at Provider's facility from June 26, 2001, through June 30, 2001, where she underwent preauthorized spinal surgery. Provider billed Carrier $46,557.21 for the treatment rendered to Claimant, which included charges for the hospital room in the amount of $1,980.00, implantables used in Claimant's surgery for $34,030.00, and other hospital services for $10,547.21.

Carrier made two separate reimbursement payments to Provider totaling $27,242.31.[3] Provider contended it should have been reimbursed $34,917.91 under the stop-loss method, which would have been 75% of the total bill because the total bill was over $40,000.00. Carrier asserted \

[1] Harlandale Independent School District was Claimant's employer at the time of the compensable injury and contracts with Barron Risk Management Services, Inc. for its workers' compensation claims.

[2] Both parties submitted Joint Stipulations of Fact prior to the hearing.

[3] The first amount was $21,200.80, which included $16,728 for the implantables, and a subsequent payment of $6,041.41. Carrier later requested a refund of the second reimbursement amount.

Provider's bill did not meet the stop-loss threshold because the cost of implantables was removed during an audit and Provider's bill was recalculated to less than $40,000.00. Provider sought medical dispute resolution through the Commission's MRD for additional reimbursement, and the MRD awarded additional reimbursement of $7,675.70 to Provider. Carrier timely appealed the MRD's decision to the State Office of Administrative Hearings (SOAH).

1. Reimbursement Methodologies

The Commission's Acute Care Inpatient Hospital Fee Guideline (ACIHFG) found in 28 TEX. ADMIN. CODE (TAC) § 134.401, *et seq.,* outlines several methods a provider may be reimbursed for services rendered in connection with a claimant's compensable injury. The first method is known as the standard per diem rate. Under this method, a provider is reimbursed a set amount for costs arising out of a claimant's hospital stay. For example, if a claimant's hospital stay consists of medical treatment without surgery, the per diem rate is $870.00. If a clamant's hospital stay involves surgery, the per diem rate is $1,118.00. If a claimant's hospital stay involves intensive care or cardiac care, the per diem rate is $1,560.00. *See* 28 TAC § 134.401(c)(1) - (3).

Another reimbursement method in the ACIHFG covers additional reimbursement for items used in treating a claimant's compensable injury. Under this method, items like implantables are reimbursed to a provider by reimbursing the actual cost of the item plus 10% of the actual cost. This method is to be used in addition to the per diem based reimbursement system. *See* 28 TAC § 134.401(c)(4) and (4)(A)(i).

Next, the ACIHFG specifically provides that treatment of trauma, burns, or human immunodeficiency virus (HIV) should be reimbursed at a fair and reasonable rate. *See* 28 TAC § 134.401(c)(5).

Lastly, the ACIHFG outlines the stop-loss reimbursement method. Under the stop-loss method, a provider is reimbursed 75% of the total audited charges if the audited charges exceed $40,000.00. That figure is known as the stop-loss threshold. *See* 28 TAC § 134.401(c)(6) and (6)(A)(i-v).

2. Carrier's evidence and arguments

Shonna McCauley, RN, testified she audited Provider's bill and found the only reason Provider's bill exceeded the stop-loss threshold was because of the markup for the implantables. Therefore, Ms. McCauley testified, the bill was reimbursed under the per diem method by paying Provider $4,472.00 for Claimant's four-day hospital stay, and $16,728.80 for the implantables used in Claimant's surgery.[4]

According to Ms. McCauley, under the per diem method, Provider would be entitled to $1,118.00 a day for Claimant's hospitalization, which would total $4,472.00, for a four-day hospital

[4] Under the per diem method, a hospital stay that involves surgery is reimbursed at $1,118.00 per day. Claimant's hospital stay was four days, therefore, Provider was reimbursed $4472.00 for Claimant's hospital stay. Also under the per diem method, implantables are reimbursed at actual cost of the implantables plus 10%. In this case the actual cost of the implantables was $15,208.00, and 10% of the actual cost is $1,520.80. Therefore, Provider was reimbursed $16,728.80 for the implantables.

stay. Additionally, under the per diem method, Provider would be entitled to the actual cost of the implantables, plus 10%. The actual cost of the implantables was $15,208.00, therefore, the actual cost plus 10% would equal $16,728.80. Consequently, the sum of the per diem rate for the hospital stay ($4,472.00) and the implantables ($16,728.80) equaled $21,200.80 - Provider's initial reimbursement.

Ms. McCauley asserted Carrier was entitled to reimburse Provider under the per diem method because if not for the markup of the implantables, the bill would not have exceeded the stop-loss threshold. Ms. McCauley stated that based on her many years of experience auditing medical bills, the charge for the implantables was high. Ms. McCauley testified she audits bills from providers located in San Antonio, Houston, and the Rio Grande Valley, and in the past has authorized reimbursement to other providers at the per diem rate (cost plus 10%) for implantables even though the entire bill initially exceeded the stop-loss threshold.

After Carrier made its initial reimbursement of $21,200.80, Provider filed a request for reconsideration. Ms. McCauley testified her office consulted the Commission on this matter, and later received an e-mail from Mary S. Mathis of the Commission's MRD. The e-mail advised Carrier that if a provider's audited charges exceed $40,000.00, the entire bill should be reimbursed at 75%, under the stop-loss method. Ms. McCauley testified Carrier then issued a supplemental reimbursement of $6,041.41, even though she did not agree with Ms. Mathis' position.

Later, after the MRD issued its finding, Carrier reviewed a past SOAH decision 453-00-2092.M4,[5] and, based on its review of the decision, Carrier determined its initial reimbursement to Provider was sufficient and requested a refund from Provider for the supplemental reimbursement. Ms. McCauley further testified her understanding of that SOAH decision was that a carrier was entitled to audit a provider's bill and reduce the amount of implantables to cost plus 10%.

Therefore Carrier argued, reducing the implantables charge to cost plus 10% was merely part of its auditing process, which Carrier asserted was proper.

3. Provider's evidence and arguments

Provider agreed that Carrier was entitled to audit every portion of Provider's bill, but argued it could only reduce the amount of a charged item to the Provider's usual and customary charge. Provider established that Ms. McCauley did not know, nor did she attempt to find out Provider's usual and customary fee for the implantables. Additionally, Provider established Ms. McCauley did not know what the usual and customary charges for implantables were for any of the other hospitals in the Methodist care system in San Antonio, Texas.[6] Furthermore, Provider established Ms. McCauley worked with an auditing staff and not in a billing department and had no knowledge of what is considered in calculating a product markup.

[5] Docket No. 453-00-2092.M4, ALJ Georgie Cunningham, signed April 24, 2001. ALJ Cunningham concluded the carrier in that case should be allowed to reduce charges for implantables to cost plus 10% when calculating whether a bill exceeds the stop-loss threshold.

[6] The Methodist Care System in San Antonio, Texas, includes Southwest Texas Methodist Hospital, Northeast Methodist Hospital, Metropolitan Methodist Hospital, and the Nix Hospital.

Kimberly Brown, an employee of HCA Healthcare, testified she had personal knowledge of Provider's billing practices, and that the amount charged for the implants in this case was Provider's usual and customary charge. Part of Ms. Brown's job duties include making sure Provider's bills are accurate in terms of the services rendered and appropriate fees.

According to Ms. Brown, Provider's charges for items and services are determined by an electronic "chargemaster" system. Ms. Brown testified the system is generally designed to recover costs not listed on the hospital bill like housekeeping, custodial, and kitchen services. The markup for the implantables in this case was calculated in the chargemaster system to recover the costs of ordering, delivery, storage, and sterilization of the implantables. Ms. Brown testified the chargemaster system is based on a series of algorithms in determining the proper cost of an item or service. However, Ms. Brown admitted she did not know how any of the algorithms functioned in order to calculate a fee. Furthermore, Ms. Brown testified the charges are predetermined by the chargemaster and her only responsibility is to make sure the billed charges match the corresponding fees on the chargemaster.

4. Analysis

Provider argued Carrier should have used the stop-loss reimbursement method under 134.401(c)(6)(A)(ii) because even after an audit, the total amount of audited charges would have exceeded the stop-loss threshold. At the heart of this dispute is Provider's charge for implantables used in Claimant's surgery. Was it reasonable for Carrier to reduce the implantables charge to the per diem rate before it determined the per diem method was applicable? Under these circumstances, the answer is yes because the rules governing reimbursement are vague and open to interpretation.

1. Construction of the ACHIFG leads to confusion

There is no question the ACHIFG contains ambiguous and arguably contradictory language. For instance, 134.401(c)(2) states, "*all* inpatient services provided by an acute care hospital for medical and/or surgical admissions will be reimbursed using a service related standard per diem amount." (Emphasis added) If "all" services really means all services, one may question the point to having subsections that address additional reimbursements, reimbursements for certain ICD-9 codes, or the stop-loss method.

By its construction, the first method of reimbursement addressed in the ACHIFG is the per diem method under 134.401(c)(1). The following three subsections relate to the per diem method of reimbursement: (c)(2) method, (c)(3) reimbursement calculation, and (c)(4) additional reimbursements. Following those subsections is the subsection outlining reimbursement for certain ICD-9 codes at 134.401(c)(5). While the ICD-9 codes themselves are not relevant in this dispute, it is important to note its position in the statute. Finally, under 134.401(c)(6), the stop-loss method is outlined. Carrier's argument is persuasive that, based on the construction of the ACHIFG, the subsections following 134.401(c)(1) and (2) serve as addendums[7] and/or exceptions[8] to the rule.

[7] 134.401(c)(3)-(5).

[8] 134.401(c)(6).

The confusion of the statute can been seen in Carrier's application of a hybrid reimbursement method. Upon receipt of Provider's $46,557.21 hospital bill, Carrier performed an audit and opined the charge for the implantables ($34,030.00) was too high. Due to the apparent markup for the implantables, Carrier removed the charge for the implantables and reimbursed Provider for the actual cost of the implantables, plus 10%. Once the cost of implantables was removed, Carrier reimbursed Provider the per diem rate for Claimant's four-day surgical hospital stay. Subsequently, Carrier took the total billed charges for the hospital room and services ($12,527.21), subtracted the amount it previously remitted when it applied the per diem method ($4,472.00), and reimbursed the remaining costs ($8,055.21) using the stop-loss method. The total supplemental payment was $6,041.41, or 75% of $8,055.21.

2. 134.401(c) contains three different reimbursement methods

Carrier asserted a closer review of the entire statute sheds light on which reimbursement method is proper. Conversely, Provider argued that only a simple and direct review of 134.401(c)(6) was necessary in determining which method was proper. In essence, Provider would want the ALJ and other reviewers to skim over most of the statute and focus only on the one subsection and its sub-parts that address the stop-loss method. This approach is inherently questionable. Why not consider the per diem method before the stop-loss method? Why was the statute constructed by placing the per diem method and its relevant subsections before the subsections that address the ICD-9 codes and before the stop-loss reimbursement method. The ALJ believes, as does the Carrier, that the sections regarding the the ICD-9 codes and stop-loss method are meant to be exceptions to the per diem method of reimbursement.

Under 134.401(c)(1), a hospital stay requiring surgery is reimbursed at the per diem rate of $1,118 a day. However, if that hospital stay requires the use of implantables or prosthetics, rule 134.401(c)(4) entitles the hospital to be reimbursed for those items at cost plus 10%, in addition to reimbursement they are entitled to under the per diem rate.

If the hospital stay involves trauma, burns, or HIV treatment, the entire treatment shall be reimbursed at a fair and reasonable rate under 134.401(c)(5). This subsection serves as the first exception to the per diem reimbursement method. Here, a provider will be reimbursed at a fair and reasonable rate rather than a predetermined amount due to the varying degrees of treatment necessary to treat patients exhibiting trauma, burn, or HIV symptoms. As noted earlier, it is not relevant as to "what" this section addresses, but rather it is relevant as to "where" this section is located in the statute - before the stop-loss exception.

If the hospital stay incurs "unusually costly services," the ACHIFG provides another exception to the per diem method. In this case, the reimbursement for the "costly" treatment will be assessed using the stop-loss method under 134.401(c)(6).

3. Stop-loss method is for unusually costly services

Pursuant to 134.401(c)(6), the stop-loss method was established to ensure fair and reasonable compensation to a hospital for unusually costly services. Should a provider, who believes it should be reimbursed under the stop-loss method, be required to show how the claimant's hospital stay required "unusually costly services?" Based on the construction of the statute, Provider would have

benefitted by offering evidence that the charges were unusually costly because, in the opinion of the ALJ and Carrier, the stop-loss method is an apparent exception to the per diem method.

In this case, there was no showing that Claimant's hospital stay incurred unusually costly services. There was no evidence that the surgical procedure was performed with complications.

There was no evidence that the implantables used in Claimant's surgery were extraordinary or unusual. The only reference made regarding the implantables markup was Provider's assertion that it was necessary to recover costs of ordering, storage and sterilization of the implantables. However, none of the costs for ordering, storage, or sterilization were supported by any evidence.

4. Carrier may reduce charges lower than Provider's usual and customary rate

Provider did not contend Carrier was not allowed to reduce the charge for the implantables as part of an audit. In fact, Provider agreed an audit of the entire bill was permissible. The point of Provider's entire case rested on the assertion that Carrier, although entitled to audit the bill, was only entitled to reduce the implantables charge to Provider's usual and customary rate.[9]

The Commission agreed in its Statement of Matters Asserted (Statement) that Carrier was entitled to audit Provider's bill, including the implantables, but could only reduce the implantables charge to Provider's usual and customary rate.[10] Both Provider and Commission asserted that once Carrier has determined Provider's usual and customary fees, Carrier can only subtract charges for treatment not related to the compensable injury, and come up with the total audited charges.[11] If, according to Provider and Commission, the audited charges exceed the stop-loss threshold of $40,000, the stop-loss reimbursement method should be applied. This argument is flawed because it neglects to consider the manner in which Provider can establish its usual and customary rate for any given item.

The actual cost for the implantables was $15,208.00, and the billed amount was $34,030.00, which reflected a markup of approximately 223%. Is it fair that a provider who bills an item at a markup of 223% be exempt from audit reductions just because it bills the same item at the same markup over and over again? It does not make sense that a provider can repeatedly bill an item at a 223% markup and anoint this charge as its usual and customary rate, thereby harboring it from any possible audit reductions. To do so would give providers an unreasonable advantage in setting reimbursement rates by allowing auditors the ability to only reduce a provider's bill to the provider's usual and customary rate and eschew all other standards.[12]

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[9] Under 28 TAC 134.401(b)(2)(A)(ii-iii), a provider shall be reimbursed its usual and customary charges, or under one of the methods set out in 134.401(c), whichever is less.

[10] The Commission's Statement of Matters Asserted, dated April 25, 2003.

[11] *See Id.* at pages 10-11.

[12] 453-00-2092.M4, dated April 24, 2001. ALJ Cunningham wrote, "allowing hospitals to set their own charges for implantables and then removing carriers' abilities to audit charges, thereby forcing them to pay inflated bills, leads to absurd results."

This unsound viewpoint was expressed in the Commission's Statement where it pointed out, "whether the stay was unusually costly or lengthy will be determined by the (provider's) >usual and customary' rate."[13] Under this scheme, the duty of assessing whether a hospital stay was costly, rests solely in the hands of the provider. Consequently, a provider need only submit evidence of its habitual "costly" invoices rather than provide evidence of the stay that made it costly. For instance, if Provider presented evidence that Claimant's surgery had complications, or Claimant's condition required the implementation of unusual or extraordinary implantables, that evidence would go a long way in substantiating Provider's costly charges. Evidence alone of usual and customary billing practices does very little to ensure quality health care and achieve effective medical cost control.[14]

5. Provider's Chargemaster system

Provider's testimony regarding its uniform billing system (chargemaster) was not persuasive. Provider testified it billed for the implants based on the algorithms contained in its chargemaster system. Ms. Brown admitted she did not participate in creating the chargemaster system, nor does she have any knowledge of the algorithms contained in the system. Ms. Brown testified the system was created by a "team of Chief Financial Officers" throughout the Methodist Hospital System. In the ALJ's opinion it is not unreasonable to infer that a team of CFO's probably had more interest in ensuring financial stability for the hospital system than complying with Commission rules when the algorithms of the chargemaster system were developed. That is not to say the CFOs created the chargemaster system with blatant disregard for the Commission's rules. Instead, the ALJ contends, the evidence presented that Provider relied on its chargemaster system when it billed for Claimant's hospital stay was simply not persuasive given that the algorithms behind the system were not examined.

5. Conclusion

Provider argued Carrier's assertion that the statute be read in its entirety was an attempt to "muddy" a clear provision. However, after a plain reading of the statute, it is obvious the statute is ambiguous and open to interpretation. The contentions of Provider and the Commission attempt to oversimplify rather than streamline a process that is meant to provide for fair and reasonable payments for services provided to claimants injured after January 1, 1991.[15] The Provider and Commission's strict interpretation of the statute also neglects to consider the statutory standard to achieve effective medical cost control.[16]

Based on the foregoing reasons, the ALJ believes Carrier was entitled to utilize the per diem reimbursement method. Because the per diem method is proper, Carrier's initial payment of $21,200.80 was sufficient. Carrier's supplemental payment of $6,041.41 should be refunded.

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[13] The Commission's Statement of Matters Asserted, dated April 25, 2003, footnote 12.

[14] *22 Tex. Reg. 6267 (1997).*

[15] *See Id. at 6265.*

[16] *See Id. at 6296.*

II. FINDINGS OF FACTS

1. ____ (Claimant) sustained a compensable injury while working for the Harlandale Independent School District (Carrier) on ___.

2. From June 26, 2001, through June 30, 2001, Claimant was treated for her injuries at Methodist Specialty & Transplant Hospital (Provider).

3. Provider submitted an itemized bill to Carrier for $46, 557.21.

4. Carrier initially reimbursed Provider $21,200.80, and made a subsequent payment of $6,041.41.

5. Provider requested medical dispute resolution from the Texas Worker's Compensation Commission's (the Commission) Medical Review Division (MRD).

6. On August 14, 2002, MRD issued Findings and Decision ordering Carrier to remit an additional $7,675.70 to Provider based on the stop-loss methodology of the Acute Care Inpatient Hospital Fee Guideline (ACIHFG) issued by the Commission in 1997.

7. Carrier timely appealed the MRD's decision to the State Office of Administrative Hearings (SOAH).

8. Notice of the hearing in this case was mailed to the parties on April 4, 2003. 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.

9. The hearing convened on April 27, 2003, before Steven M. Rivas, Administrative Law Judge (ALJ). Carrier was represented by LeeAnna G. Mask, attorney. Provider was represented by R. Scott Placek, attorney. The record remained open until May 5, 2003.

10. Claimant was hospitalized for four days at Provider's facility and underwent pre-authorized spinal surgery, which included the use of implantables.

11. Carrier audited Provider's bill and reimbursed Provider using the ACIHFG's per diem method.

12. Carrier reimbursed Provider $4,472.00 for four days of hospitalization based on the number of days preauthorized with the surgery.

13. Provider purchased the implantables for $15,208.00, and submitted a $34,030.00 charge to Carrier for the implantables.

14. Carrier reduced the amount of reimbursement for the implantables to the cost of the implantables plus 10%.

15. The ACIHFG's stop-loss method is one exception to the per diem reimbursement method.

16. A provider shall be reimbursed under the stop-loss method if it incurs unusually costly services.

17. A carrier, as part of its audit, may reduce a provider's charge for implantables to an amount lower than the provider's usual and customary rate.

18. If a provider's audited charges do not meet the stop-loss threshold of $40,000.00, the provider shall be reimbursed at the per diem rate.

III.
CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to TEX. LAB. CODE ANN.§ 413.031.

2. 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.

3. Proper and timely notice of the hearing was effected upon the parties according to TEX. GOV'T CODE ANN. § 2001.052 and 28 TAC § 148.4.

4. Carrier had the burden of proof on its appeal by a preponderance of the evidence, pursuant to TEX. LAB. CODE ANN. § 413.031 and 28 TAC §148.21(h).

5. Carrier had a right to audit Provider's bill under 28 TAC § 134.401(b)(2)(C).

6. All inpatient services provided by an acute care hospital for a surgical admission will be reimbursed using a standard per diem amount under 28 TAC § 134.401(c)(2).

7. The standard per diem amount for a surgical admission is $1,118.00, as set forth in 28 TAC § 134.401(c)(1).

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

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

9. Based on the actual cost of the implantables to Provider, Provider is entitled to reimbursement of the actual cost, plus 10%, totaling $16,728.80 for the implantables under 28 TAC §§ 134.401(b)(2)(B) and (c)(4)(A).

10. By applying the formula specified in Conclusion of Law No. 8 and adding the additional reimbursement, as specified in Conclusion of Law No. 9, the Provider's bill should be calculated as follows:

4 days	x	$1,118.00	' $4,472.00
$4,472.00	+	$16,728.80	' $21,200.80

11. The total audited charges of $21,200.80 did not exceed the stop-loss threshold of $40,000.00, pursuant to 28 TAC § 134.401(c)(6)(A)(i).

12. Based on Conclusion of Law No. 11, Provider's bill does not qualify for the stop-loss method of reimbursement pursuant to 28 TAC § 134.401(c)(2)(C).

13. Carrier owes Provider a total reimbursement of $21,200.80, as specified in 28 TAC §134.401(c)(2)(A)(B), (3) and (4).

14. Based on Finding of Fact No. 4, Carrier reimbursed Provider $27,242.21.

15. Based on the foregoing Findings of Fact and Conclusions of Law, Carrier does not owe Provider any additional reimbursement, and Provider must refund Carrier $6,041.41.

ORDER

IT IS ORDERED THAT the appeal of Harlandale Independent School District is granted, Carrier is not ordered to remit any additional reimbursement to Methodist Specialty & Transplant Hospital, and Provider is ordered to refund Carrier $6,041.41.

Signed this 3rd day of July 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

_____

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE