SOAH DOCKET NO. 453-03-3581.M4
TWCC MDR NO. M4-03-0554-01

BAYLOR UNIVERSITY MEDICAL CENTER,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
NATIONAL FIRE INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. DISCUSSION

Baylor University Medical Center (Provider) appealed the Findings and Decision of the Texas Workers' Compensation Commission (Commission) acting through its Medical Review Division, denying additional reimbursement for an inpatient operative procedure provided to injured worker ___ (Claimant).

After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that National Fire Insurance Company (Carrier) is required to reimburse Provider the additional requested sum of $3,539.67.

The hearing convened on November 6, 2003, with ALJ Bill Zukauckas presiding. Petitioner appeared by phone through its designated representative, Shannon Arthur, R.N. Carrier appeared through its designated representative, James M. Loughlin, attorney. The hearing concluded and the record closed that same day. Neither party objected to notice or jurisdiction.

1 Background and Overview

This case deals with the issue of the appropriate reimbursement for an inpatient hospital stay. Provider seeks additional reimbursement for an in-patient operative procedure arising from a workplace injury. Provider billed Carrier $78,584.13 for the o perative procedure, inpatient stay, and associated costs. Carrier reimbursed Provider. Carrier represents that it incorrectly used the Commission's stop-loss reimbursement methodology to calculate a reimbursement of $55,398.43. It represents that it reimbursed the reduced bill (minus carve-outs) at 75 percent under the stop-loss methodology for an overall effective reimbursement of 70.5 percent. Provider requests additional reimbursement of $3,539.67 based on its calculation of a fair and reasonable reimbursement at an effective rate of 74 percent of total billed costs.

The methods for reimbursing a Provider are established in the Acute Care Inpatient Hospital Fee Guideline (HFG), effective August 1, 1997. HFG is applicable for all reasonable and medically

necessary medical and/or surgical inpatient services rendered in a Facility to injured workers under the Texas Workers' Compensation Act.[1] Generally, a facility is reimbursed at a fixed per diem rate for inpatient surgical procedures performed in the facility.[2] Generally, if the total audited charges for a hospital admission exceed $40,000, the stop-loss methodology is applied in lieu of the per diem rate.[3]

This case, however, represents an exception to those two general rules. Because the primary admission code for the injured worker is trauma and because the Commission has deemed trauma admissions more costly than average, Provider's reimbursement warrants special treatment under the rules. As a trauma diagnosis, whether or not the admission billing exceeds $40,000, the entire admission is to be reimbursed at a fair and reasonable rate.[4] After reviewing the evidence in this case, however, the ALJ finds that the use of the stop-loss reimbursement methodology is also not precluded by the rules and represents a fair and reasonable reimbursement in this case.

2. Summary of the Guideline Provisions

The in-patient acute care reimbursement methodologies are set forth in Section 134.401(c) of the Commission's rules. Subsection (c)(1), addressing the per diem methodology, specifies that, generally, a surgical admission is reimbursed at $1,118 per day. Subsection (c)(2) states, "All inpatient services provided by an acute care hospital for . . . surgical admissions will be reimbursed using a service related standard per diem amount." According to Subsection (c)(2)(C), independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold.

Additional reimbursements are addressed in more detail in Section 134.401(c)(4). The items listed are reimbursed in addition to the normal per diem amount. The rules make clear that the additional reimbursements apply only when the per diem rather than per stop-loss methodology is used. Implantables, one of the two carve-out categories at issue here, shall be reimbursed at cost to the hospital plus 10 percent, pursuant to Section (c)(4)(A)(i). The other carve-out category at issue, blood and blood services, is to be reimbursed at a fair and reasonable rate per Section (c)(4)(B)(iv).

Although the stop-loss reimbursement methodology is not mandated for a trauma case, it is discussed below because the ALJ finds it provides a fair and reasonable reimbursement methodology in this case. Section 134.401(c)(6) addresses the stop-loss provision. It is an independent reimbursement methodology used to ensure fair and reasonable compensation to hospitals for unusually costly and extensive services.[5] This methodology is used in place of and not in addition to the per-diem-based reimbursement system.

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[1] 28 TEX. ADMIN. CODE (TAC) § 134.401.

[2] 28 TAC § 134.401(c).

[3] 28 TAC § 134.401(c)(6).

[4] 28 TAC §134.401(c)(6).

[5] Although as previously noted, trauma are expensive on a per day basis and get special reimbursement consideration.

The total audited charges must exceed $40,000 to be eligible for stop-loss reimbursement in lieu of a per diem rate.[6] According to Subsection (c)(6)(A)(v), audited charges are those charges which remain after a carrier's bill review. Audited charges multiplied by the stop-loss factor of 75 percent yield the reimbursement amount.

Under Subsection (c)(5)(A-C), however, admissions where the primary ICD-9 diagnosis code is listed as trauma, burns, or human immunodeficiency virus, the entire admission shall be reimbursed at a fair and reasonable rate. Because this particular case involves a trauma admission, the entire admission is to be reimbursed at a fair and reasonable rate.

3. Determining Fair and Reasonable Reimbursement

Petitioner offered evidence showing that it had managed-care contracts that allowed it to receive reimbursement ranging anywhere from 50 percent of billed costs to 92 percent of billed costs. It put on evidence to prove that the fair and reasonable rate for this case was 74 percent based on calculating an unweighted average of all its managed care contracts.

Carrier argued that a fair and reasonable rate ought to be based on the Commission's per diem set rates. Alternatively, it suggested Provider's very lowest negotiated contract rate, 50 percent, should be used because obviously Provider considered this rate appropriate for some select customer group. Consequently, Provider must be making money at that rate. As a result, Carrier argues this very lowest rate must be fair and reasonable and should be used.

The ALJ finds the Provider met its principal burden of proof in this case. Provider has produced evidence to demonstrate that fair and reasonable rate is somewhere in the range between 72 and 75 percent of overall billed hospital costs. The stop-loss methodology provides a "fair and reasonable" reimbursement that achieves this objective.

The ALJ finds the process of determining a true fair and reasonable hospital charge to be difficult. That said, the ALJ applauds Provider's approach of calculating a fair and reasonable rate through its negotiated contracts, although a true weighted average would better approximate the true average reimbursement rate. The ALJ takes notice that the preamble to the 1997 HFG mentions average stop-loss reimbursement rates for managed care contracts within Texas in 1994-95 as 72 percent. For unexplained reasons, it has decided to use 75 percent for the stop-loss reimbursement in the HFG rather than the 72 percent average. The ALJ adopts that 75 percent figure, too, for this case, especially in light of the 74 percent average calculated at Provider's facility. Based on the above figures, the ALJ finds the stop-loss reimbursement factor of 75 percent, rather than the per diem, plus carve out, reimbursement methodology, ought to be the presumed floor for calculating fair and reasonable rates.

The ALJ notes that the 1997 HFG preamble repeatedly discusses the extra costs involved in trauma and burn cases and finds that it would make no sense, knowing that these cases are recognized as more expensive to a hospital on a daily basis, to reimburse these cases that would otherwise meet the stop-loss threshold of $40,000, at some rate lower than the 75 percent stop-loss

[6] Total audited charges in this case minus the carve-outs was $66,512.74. This figure well exceeds the $40,000 Stop-loss threshold and, therefore, there is no issue about carve-outs being inflated simply to reach this threshold.

reimbursement rate for less costly admissions. As a practical matter, proving a higher fair and reasonable rate would be difficult on a cases by case basis, and this analysis gives facilities and carriers a reliable and consistent rule-of-thumb reimbursement methodology for all cases meeting the stop-loss dollar threshold. The ALJ notes that this is what the Carrier's billing staff has done as a matter of course in this case anyway, with the exception of the way it has reimbursed blood carve-outs.

4. Carve-Outs

Carve-outs are charges for facility cost items that the Commission has designated as sometimes needing special billing treatment. In this case, the carve-outs total $12,071.42 and consist of implants (billed under revenue code 278), for a total cost of $3,218.92; blood storage (billed under revenue code 390), for a total charge of $7,799.50; and blood administration (billed under revenue code 391), for a total charge of $1,053.00.

The 1997 HFG allows carve-out procedures to bill certain hard costs to be billed separately where the facility receives a per diem rate rather than a stop-loss rate. As an example, over and above the per diem reimbursement rate, hospitals can also recover their cost of implants, plus 10 percent over that cost. Once the stop-loss reimbursement begins, the Guidelines contemplate that the cost of carve-outs are included within the stop-loss reimbursement. Some past SOAH decisions, however, have held that costs for implants should calculated separately, at cost plus 10 percent, to determine whether the stop-loss threshold has been met. The rationale has been that there is a tendency for facilities to inflate those implatable cost sometimes 200-300 percent, just to reach the stop-loss threshold. Even though this is not a stop-loss case *per se* and even though there is not question that the bill is well over $40,000, even without carve-out costs, the ALJ recommends the implants here be carved out and reimbursed at cost plus 10 percent for the reasons addressed above. In this case, the total implant cost is $2,428.93, which multiplied by 110 percent, yields a reimbursement for implants of $2,671.82.

With regard to the blood storage billed at a total charge of $7,799.50, and blood administration billed at a total charge of $1,053.00, that pursuant to Section 9(c)(4)(B) of the Guidelines, that these charges are to be reimbursed at a "fair and reasonable rate." The Carrier's reimbursed for blood billings at Provider's cost, plus 10 percent. The ALJ finds this is incorrect and does not represent a fair and reasonable rate required by the rules. The 75 percent stop-loss reimbursement rate is fair and reasonable for Provider's services generally and because no evidence was presented rebutting the presumption that these costs ought to be reimbursed at a rate lower than the overall reasonable rate, he applies that 75 percent factor to the following blood costs:

$7799.50 x 75% ' $5849.62
$1053.00 x 75% ' $789.75

The ALJ finds total fair and reasonable costs of $6,639.37 for the storage and administrative services.

II. CONCLUSION

The ALJ finds that Provider has incurred fair and reasonable costs of $49,884.53 representing the audited total minus-carve outs of $66,512.74 multiplied by 75 percent), plus implant charges of $2,671.82 (at cost plus 10 percent) and fair and reasonable blood storage and administration costs of $6,639.37 (representing billed amount multiplied by the stop-loss multiplier of 75 percent), for overall reimbursable costs of $59,195.72. From those costs, Carrier has already reimbursed provider $55,398.43, leaving $3,797.27 of unreimbursed costs. Because Provider has only plead its case asking for a lessor amount of $3,539.67, that is the figure Carrier is required to reimburse.

III. FINDINGS OF FACT

1. ___ (Claimant) was admitted to Baylor Medical Center for a October 31, 2001 to November 16, 2001, inpatient operative procedure arising from a traumatic workplace injury.

2. Provider billed Carrier $78,584.13 for the operative procedure, inpatient stay and associated costs. Carrier reimbursed Provider $55,398.43. Carrier based its reimbursement using the TWCC Commission's stop-loss methodology (stop-loss), excepting surgical implants and blood services, and paid the reduced bill at 75 percent.

3. The Acute Care Inpatient Hospital Fee Guideline (HFG), effective August 1, 1997, is applicable for all reasonable and medically necessary medical and surgical inpatient services rendered in an acute care hospital (facility) to injured workers under the Texas Workers' Compensation Act.

4. Generally, a facility is reimbursed at a fixed per diem rate for inpatient surgical procedures performed in the facility. However, if the total audited charges for a hospital admission exceed $40,000 (minimum stop-loss threshold), a stop-loss methodology is applied in lieu of the per diem rate, except that traumatic injuries, as in this case, are billed at a fair and reasonable rate.

5. ___ (Claimant)'s injury was caused by a trauma, and the billing for that treatment well exceeded the $40,000 stop-loss threshold.

6. The stop-loss reimbursement methodology was established by the Commission to ensure fair and reasonable compensation to a facility for unusually costly services rendered during treatment to an injured worker.

7. When the stop-loss reimburse methodology is used by a facility, the facility is reimbursed 75 percent of the post-audit charges.

8. Provider was able to show that use of the stop-loss methodology to arrive at a reimbursement rate (using a 75 percent reimbursement factor) would be fair and reasonable.

    1. Provider showed that its approximate average managed care contract reimbursement rate was approximately 74 percent.

    2. The Commission has determined that the average statewide stop- loss reimbursement rate for managed care contracts of all kinds was 72 percent in 1994-95.

3. Trauma admissions are more costly than average worker's compensation admissions that are reimbursed by the stop-loss methodology. The stop-loss reimbursement methodology is a reasonable, presumptive floor for trauma reimbursements when the stop-loss threshold is reached.

9. The appropriate reimbursement for surgical implants in this case is cost ($2,428.93) multiplied by 110 percent, for a total implant reimbursement of $2,671.82.

10. Blood services billed under revenue codes 390 and 391 are appropriately reimbursed at the fair and reasonable rate of 75 percent of billed amounts for this case, for a total blood service reimbursement of $6,639.37.

11. The total audited costs of $66,512.74 for Provider's services, multiplied by the stop-loss rate of 75 percent, yields fair and reasonable reimbursement of $49,884.53**,** excluding carve-out services.

12. Fair and reasonable costs of $49,884.53, fair and reasonable blood services costs of $6,639.37, and implants billed at cost plus 10 percent, or $2,671.82, yields total overall reimbursable costs of $59,195.72.

13. Reimbursable costs of $59,195.72 minus reimbursements to date of $55,398.43 yields $3,797.27 of unreimbursed costs.

14. Provider's request for an additional reimbursement of $3,539.67 is lower than its unreimbursed costs of $3,795.27.

15. The Commission, acting through its Medical Review Division (MRD), denied Petitioner's additional reimbursement request for $3,539.67, for an inpatient operative procedure provided to Claimant.

16. Based on the MRD decision, Provider timely requested a hearing before the State Office of Administrative Hearings (SOAH). The hearing convened on November 6, 2003, with SOAH Administrative Law Judge Bill Zukauckas presiding. Provider appeared through its designated representative, Shannon Arthur, R.N. Respondent appeared through its designated representative, James M. Loughlin, attorney. The hearing concluded and the record closed that same day.

III. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. §413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE (TAC) ch. 148.

3. The request for a hearing was timely made pursuant to 28 TAC § 148.3.

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

5. Petitioner has the burden of proof in this matter. 28 TAC §§ 148.21(h) and 133.308(w).

6. Reimbursement using a fair and reasonable methodology, rather than employing the stop-loss or per diem reimbursement, is required for this trauma admission. 28 TAC §134.401(c).

7. The stop-loss reimbursement methodology provides a fair and reasonable approach to calculating the appropriate reimbursement under 28 TAC §134.401(c).

8. Although Provider has $3,797.27 of unreimbursed costs, it is entitled to only the $3,539.67 requested in its pleadings.

ORDER

THEREFORE IT IS ORDERED that National Fire Insurance Company pay an additional reimbursement of $3,539.67 for charges associated with the October 31, 2001-November 16, 2001 inpatient operative procedure and associated services.

SIGNED February 11, 2004.

BILL ZUKAUCKAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS