SOAH DOCKET NO. 454-13-0855.M4
DWC NO. _____

PUBLIC WC PROGRAM,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
NORTHWEST TEXAS HOSPITAL,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Public WC Program (Carrier) challenges calculations contained in a Medical Fee Dispute Resolution decision (MDR Decision) by the Texas Department of Insurance (TDI), Division of Workers' Compensation (Division). The MDR Decision calculations show that Carrier should pay additional reimbursement to Northwest Texas Hospital (Provider) for outpatient facility services provided to an injured worker (Claimant) on December 9, 2010. The Administrative Law Judge (ALJ) finds that the MDR Decision correctly calculates that Carrier should reimburse Provider $4,181.93, including an outlier payment for CT scans. Carrier has already paid Provider $1,473.21. Accordingly, Carrier is to reimburse Provider the balance of $2,708.72.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

There are no disputed issues of notice or jurisdiction. Those matters are set out in the Findings of Fact and Conclusions of Law sections of this Decision and Order without further discussion here.

Provider requested $15,476.70 in reimbursement from Carrier for December 2010 services provided to Claimant. Carrier reimbursed Provider a total of $1,473.21 and denied Provider's subsequent request for reconsideration.[1] Provider's resulting request for medical fee dispute resolution was received by the Division on September 12, 2011.[2] The Division issued its

[1] Carrier Ex. 2. The ALJ notes that Provider's letter requesting reconsideration should have been dated January 17, 2011, instead of January 17, 2010.

[2] Carrier Ex. 3 at 20.

MDR Decision on October 9, 2012, holding in Provider's favor.[3] On October 26, 2012, Carrier requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the MDR Decision. On November 8, 2012, the Division issued a Notice of Hearing.

The hearing was held January 8, 2013, before ALJ Sharon Cloninger, at SOAH, William P. Clements State Office Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Carrier was represented by Steven M. Tipton, attorney, who appeared in person. Provider was represented by Karen Lynch, Workers' Compensation Representative with Healthcare Recovery Alliance, who appeared by telephone. The hearing concluded and the record closed on January 8, 2013.

II. DISPUTED REIMBURSEMENT

On _____, Claimant sustained compensable injuries to his head, neck, and shoulder. After his initial treatment, he complained of persistent mild headaches. In December 9, 2010 follow-up treatment at Provider's outpatient facility, he underwent lab tests, an EEG, and a series of CT scans of the head, neck, and shoulder, as ordered by his neurologist.

The MDR Decision requires Carrier to reimburse Provider a total of $4,181.93 for Claimant's lab tests, EEG, and series of CT scans. Provider agrees with the MDR Decision. Carrier does not dispute the MDR Decision award of $315.59 for the lab tests and EEG: CPT 36415 ($3.75); CPT 82565 ($9.18); CPT 84520 ($7.06); CPT Q9967 ($0.00); and CPT 95819 ($295.60). Carrier also does not dispute that it should pay $1,146.42 for the series of CT scans—CPT codes 70470, 70496, 70498, and 73200—which fall into consolidated Ambulatory Payment Classification (APC) 8006.[4] What Carrier contests is the MDR Decision's calculation for APC 8006 that includes an outlier payment, resulting in a total award for APC 8006 of $3,866.34 instead of $1,146.42.

[3] Carrier Ex. 1.

[4] Carrier Ex. 3 at 27.

Carrier contends that Provider is not entitled to an outlier payment for APC 8006 because, to qualify for an outlier payment, Provider must show the CT scans were "extraordinarily costly."[5] Carrier points out that Claimant's CT scans were performed in an outpatient setting some two months after his injury; the CT scans posed no excessive or significant financial risk to Provider;[6] there is no evidence of complications with Claimant or the procedures; and the procedures were routine tests. Therefore, Carrier concludes, the CT scans were not "extraordinarily costly" and the outlier payment is not warranted.

Provider's position is that the CT scans qualify for an outlier payment under the fee guidelines that became effective in 2008.[7]

III. APPLICABLE LAW

A. 28 Texas Administrative Code § 134.403

The TDI rule at 28 Texas Administrative Code § 134.403 (the rule) applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008. Claimant's treatment was provided in an outpatient hospital setting on December 9, 2010. Therefore, the rule applies to this case.

The rule requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register* together with the application of minimal modifications as set forth in the rule. In this case, the rule's applicable minimal modification requires the sum of the

[5] Carrier's Pre-Submission Brief at 2.

[6] Carrier's Pre-Submission Brief at 9.

[7] Carrier Ex. 1 at 2.

Medicare facility specific reimbursement amount and any applicable outlier payment amount to be multiplied by 200%.[8]

1. Medicare Facility Specific Amount

The Centers for Medicare & Medicaid Services (CMS) began using the OPPS in August 2000. The OPPS is largely a fee schedule.[9] CMS determines the payment rate for each service by multiplying the relative weight for the service's APC by a conversion factor. The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC. The conversion factor translates the relative weights into dollar payment rates. To account for geographic difference in input prices, CMS adjusts the labor portion of the conversion factor (60%) by the hospital wage index.[10] CMS does not adjust the remaining 40% of the conversion factor.[11] A full list of APCs is published annually in the OPPS final rules which are publicly available through the CMS website.[12]

In the instant case, APC 8006 applies to Claimant's CT scans. Medicare will pay for multiple imaging procedures performed during a single session using the same imaging modality by applying a composite APC payment methodology.[13] If multiple imaging procedures within a CT scan family are performed with and without contrast on the same date of service, then the "with contrast' composite APC is assigned. Claimant's CT scans were performed with and without contrast.[14]

2. Outlier Payments

[8] 28 Tex. Admin. Code § 134.403(f)(1)(A); s*ee also* Carrier Ex. 1 at 3.

[9] Carrier Ex. 4, Addendum B at 7; Carrier Ex. 1 at 3.

[10] Provider's hospital wage index is 0.8534. Carrier Ex. 1 at 4.

[11] Carrier Ex. 4, Addendum B at 8.

[12] Carrier Ex. 4, Addendum B at 7; Carrier Ex. 1 at 3.

[13] Carrier Ex. 3 at 23; Carrier Ex. 4, Attachment A at 3, item 6.

[14] Carrier Ex. 3 at 23.

In addition to the standard OPPS payments, hospitals can receive outlier payments for unusually costly services. The OPPS incorporates an outlier adjustment to ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers.[15] The outlier payment is determined by calculating the cost of an OPPS line-item service,[16] including a *pro rata* portion of the total cost of packaged services on the claim, by multiplying the total charges for OPPS services by each hospital's overall cost-to-charge ratio (CCR)[17] and determining whether the total cost for service exceeds 1.75 times the OPPS payment and separately exceeds the fixed-dollar threshold determined each year.[18] If the total cost for the service exceeds both thresholds, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment.[19]

B. Burden of Proof

Carrier, as the party disputing the MDR Decision, has the burden of proving by a preponderance of the evidence that Provider is not entitled to any additional payment.[20]

IV. EVIDENCE, ARGUMENT, AND ANALYSIS

As stated above, Carrier does not dispute the MDR Decision calculation for the Medicare facility specific amount, although Carrier's own calculation shows the Medicare facility specific amount should be $575.58 instead of the MDR Decision's $573.21.[21]

---

[15] Carrier Ex. 4, Addendum B at 9, Addendum C at 27 and 31, and Addendum D at 38.

[16] If a claim includes a composite payment such as APC 8006 that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, CMS estimates a single cost for the composite APC from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. Carrier Ex. 1 at 4; Carrier Ex. 4, Addendum D at 39.

[17] Provider's 2010 CCR is 0.264. Carrier Ex. 1 at 4.

[18] The 2010 fixed-dollar threshold amount for APC 8006 is $2,175. Carrier Ex. 1 at 4; Carrier's Pre-Submission Brief at 9-10.

[19] Carrier Ex. 4, Addendum D at 38-39 and Addendum B at 9.

[20] 1 Tex. Admin. Code § 155.427.

[21] Carrier Ex. 3 at 23; Carrier Ex. 1 at 4.

The MDR Decision arrives at the Medicare facility specific amount by using the following calculations:

- The OPPS 2010 payment for APC 8006 is $628.49.
- The 2010 APC 8006 rate of $628.49 is multiplied by 60% to arrive at the unadjusted labor portion of the payment: $377.09.
- The unadjusted labor portion of the payment ($377.09) is multiplied by Provider's 2010 wage index (0.8534) for the adjusted labor portion of the payment: $321.81.
- The 2010 APC 8006 rate of $628.49 is multiplied by 40% for the non-labor related portion: $251.40.
- The sum of the adjusted labor amount ($321.81) and the unadjusted non-labor amount ($251.40) is $573.21.
- The 2010 Medicare facility specific amount for APC 8006 for Provider is $573.21.

Applying the 200% multiplier under 28 Texas Administrative Code § 134.403(f)(1) to Provider's Medicare facility specific amount of $573.21, the total amount due Provider for APC 8006, without an outlier payment, would be $1,146.42.[22]

The MDR Decision, however, goes on to include a calculation for an outlier payment, starting off by multiplying Provider's $13,690.60 in billed charges for APC 8006 by Provider's 2010 CCR of 0.264, yielding a result of $3,614.32, which Carrier characterizes as "grossly inflated."[23] Even assuming one may ignore the "extraordinarily costly" requirement, Carrier argues, $3,614.32 is irreconcilable with Provider's 2010 Outpatient Utilization Statistics for APC 8006, which show 233 patient claims with an average charge of $3,325 and an average cost of $199.[24] Carrier states that Provider's 2010 Outpatient Utilization Statistics for APC 8006

[22] Carrier's Pre-Submission Brief at 9-10. The applicable minimum modification set out at 28 Tex. Admin. Code § 134.403(f)(1)(A) requires the sum of the Medicare facility specific reimbursement amount and any outlier payment amount to be multiplied by 200%.

[23] Carrier's Pre-Submission Brief at 9.

[24] Carrier's Pre-Submission Brief at 9; Carrier Ex. 4, Addendum E at 41-42. Provider billed Carrier $13,690.60 for Claimant's four CT scans, for an average of $3,422.65 each.

yield a line item CCR of 0.060, not the CCR of 0.264 used in the MDR Decision. Even if one were to use Provider's actual billed charges of $13,690.60 for APC 8006, this actual CCR of 0.060 yields a cost of $821.44, Carrier asserts. Neither $199 nor $821.44 exceeds the 2010 annual fixed-dollar threshold for APC 8006 of $2,175. Therefore, the services for APC 8006 cannot qualify for an outlier payment, Carrier concludes.

The ALJ disagrees with Carrier's calculations for Provider's 2010 CCR. The CCR is determined annually by dividing the hospital's yearly *overall* Medicare costs by its yearly *overall* Medicare charges. [Emphasis added]. Yet Carrier's calculation divides Provider's yearly Medicare cost for APC 8006 *only* by its yearly Medicare charges for APC 8006. [Emphasis added]. However, because Provider's overall Medicare charges and costs include more than APC 8006 only, the correct 2010 CCR for Provider is 0.264, as listed on the CMS website and in the MDR Decision.[25]

Carrier next argues that Provider is not entitled to an outlier payment for APC 8006 because Provider did not demonstrate that the routine repeat CT scans were "extraordinarily costly." Carrier points out that Provider's charges for the CT scans are out of line with other similar providers and far out of line with its own published cost data.[26] Carrier's witness Jackie Beauchamp, R.N., testified that Provider's 2010 average charge for APC 8006 of $3,325 is much higher than that of other area hospitals. She said two other area acute care hospitals charged an average of $1,798 and $1,308, respectively, per outpatient CT scan provided in January 2011, a month after Claimant's disputed treatment. She testified that Provider's 2010 average cost of $199 per CT scan is more consistent with her experience as a nurse and as the owner of a company that audits bills in workers' compensation cases.[27] Ms. Beauchamp clarified that although Claimant had four CT scans, APC 8006 is a bundled composite charge, and it would not be appropriate to multiply the $199 by four to arrive at Provider's cost.

---

[25] Carrier Ex. 1 at 4; Carrier Ex. 4, Addendum C at 19; cms.gov/apps/ama/license. Provider's CMS certification number, as used on the CMS website, is 450209. Carrier Ex. 4, Addendum E at 41.

[26] Carrier's Pre-Submission Brief at 8.

[27] *See* Carrier Ex. 4, Addendum E at 41-42.

Contrary to Carrier's position, the CMS formula for calculating outlier payment eligibility does not require a provider to demonstrate that a procedure was extraordinarily costly. Instead, the formula calls for multiplying a provider's *charges*—regardless of whether those charges are reasonable or inflated—by the provider's CCR as a first step in the calculation used to determine a provider's cost related to an OPPS line-item service. [Emphasis added]. The provider's *actual costs* for a procedure are not used in the formula. [Emphasis added].[28] Therefore, while Provider's charges for Claimant's CT scans of $13,690.60 would be used in the formula, Provider's 2010 actual cost of $199 per CT scan would not be used. If Provider's total calculated cost for providing a service exceeds 1.75 times the OPPS payment and separately exceeds the fixed-dollar threshold determined each year, it is entitled to an outlier payment totaling 50% of the amount by which the cost exceeds 1.75 times the OPPS payment.[29] The ALJ finds the MDR Decision correctly awards an outlier payment to Provider, as shown in the following calculations:

- The 2010 fixed-dollar threshold for APC 8006 is $2,175.
- Provider's 2010 CCR is 0.264.
- Provider's summarized charges for APC 8006 of $13,690.60 multiplied by Provider's 2010 CCR of 0.264 equals $3,614.32.
- The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of total APC payment. The 2010 APC payment for Claimant's CT scans of $573.21 divided by the sum of all APC payments is 79.50%.[30]
- The sum of all packaged costs is $136.75. The allocated portion of packaged costs (79.50% x $136.75) is $108.72. This amount added to the service cost of $3,614.32 yields a total cost for APC 8006 of $3,723.04.
- The $3,723.04 cost of the service exceeds the 2010 fixed-dollar amount for APC 8006 of $2,175.

[28] Carrier Ex. 4, Addendum D at 38-39.

[29] Carrier Ex. 4, Addendum D at 39.

[30] Carrier Ex. 1 at 4; Carrier Ex. 4, Addendum D at 39. The MDR Decision does not identify the packaged items or specify the total cost of all packaged items. Neither party contested the 79.50% figure.

- The amount by which the cost of $3,723.04 exceeds 1.75 times the OPPS payment of $573.21(1.75 x $573.21= $1003.12) is $2,719.92.

- Multiplying $2,719.92 by 50% results in $1,359.96.

- The $573.21 APC payment for this service added to the outlier payment of $1,359.96 totals $1,933.17.

- Multiplying $1,933.17 by 200% yields a MAR of $3,866.34 for APC 8006.

Adding the APC 8006 MAR of $3,866.34 to the undisputed CPT Code amount of $315.59 results in a total allowable reimbursement of $4,181.93. This amount, less the $1,473.21 previously paid by Carrier to Provider, leaves an amount due to Provider of $2,708.72. Based on the foregoing calculations, Carrier is required to reimburse Provider an additional $2,708.72.[31]

V. CONCLUSION

Carrier does not dispute the MDR Decision's ordered reimbursement of $315.59 for Claimant's lab tests and EEG. Carrier also does not dispute a payment of $1,146.42 for Claimant's CT scans. Carrier only disputes the award of an outlier payment to Provider for APC Code 8006. The ALJ finds Carrier failed to prove that Provider is not entitled to an outlier payment.

The evidence shows that the purpose of outlier payments is to reimburse hospitals for unusually costly services. But the applicable CMS formula for determining whether an outlier payment is warranted does not require a provider to prove that a service was unusually costly. Instead, the formula calls for multiplying a provider's charges—regardless of whether they are reasonable or inflated—by that provider's CCR as the first step in determining eligibility for an outlier payment. The outlier payment calculations presented in the MDR Decision correctly apply the formula for determining outlier payment eligibility. Accordingly, the total amount Carrier should pay Provider for Claimant's December 9, 2010 treatment is $4,181.93. Carrier

[31] Carrier Ex. 1.

has already paid Provider $1,473.21 for those services. Carrier is to pay Provider the remaining balance of $2,708.72.

VI. FINDINGS OF FACT

1. Public WC Program (Carrier) challenges the Medical Fee Dispute Resolution decision (MDR Decision) by the Texas Department of Insurance (TDI), Division of Workers' Compensation (Division), requiring Carrier to provide additional reimbursement to Northwest Texas Hospital (Provider) for outpatient facility services provided to an injured worker (Claimant) on _____ (date of service).

2. On the date of service, Claimant underwent lab tests, an EEG, and CT scans of his head, neck, and shoulder in Provider's outpatient facility.

3. Provider requested $15,476.70 in reimbursement from Carrier for Claimant's treatment.

4. Carrier reimbursed Provider a total of $1,473.21 and denied additional reimbursement following Provider's subsequent request for reconsideration.

5. Provider's resulting request for medical fee dispute resolution was received by the Division on September 12, 2011.

6. The Division issued its MDR Decision on October 9, 2012, awarding Provider a total of $4,181.93.

7. On October 26, 2012, Carrier requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the MDR Decision.

8. On November 8, 2012, the Division issued a Notice of Hearing. The notice informed the parties of the time, date, and location of the hearing; the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

9. The hearing was held January 8, 2013, before Administrative Law Judge Sharon Cloninger, at SOAH, William P. Clements State Office Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Carrier was represented by Steven M. Tipton, attorney, who appeared in person. Provider was represented by Karen Lynch, Workers' Compensation Representative with Healthcare Recovery Alliance, who appeared by telephone. The hearing concluded and the record closed on January 8, 2013.

10. Carrier does not contest the MDR Decision's ordered reimbursement of $315.59 for Claimant's lab tests and EEG.

11. Carrier does not contest that the Medicare facility specific amount for Claimant's four CT scans, billed together under consolidated Ambulatory Payment Classification (APC) 8006, is $573.21.

12. Carrier does not contest that the Medicare facility specific amount for APC 8006—$573.21—should be multiplied by 200%, for a total of $1,146.42 due to Provider for Claimant's CT scans.

13. Carrier disputes the MDR Decision's finding that Provider is owed an outlier payment for APC 8006.

14. Applying the methodology found in 28 Texas Administrative Code § 134.403(f) to the charges for APC 8006 results in a maximum allowable reimbursement (MAR) of $3,866.34 for Claimant's CT scans; the MAR includes an outlier payment.

15. When the MAR of $3,866.34 for Claimant's CT scans is added to the $315.59 for his lab tests and EEG, the result is a payment amount due of $4,181.93.

16. Deducting the $1,473.21 previously paid by Carrier to Provider from the MAR of $4,181.93 leaves $2,708.72 due to Provider.

VII. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. Tex. Lab. Code § 413.031 and Tex. Gov't Code ch. 2003.

2. Adequate and timely notice of the hearing was provided to Carrier and Provider. Tex. Gov't Code §§ 2001.051 and 2001.052.

3. Carrier had the burden of proof in this proceeding by a preponderance of the evidence, as set out at 1 Texas Administrative Code § 155.427.

4. Carrier failed to prove that Provider is not entitled to the outlier amount for APC 8006. 28 Tex. Admin. Code § 134.403(f).

5. Carrier owes Provider $3,866.34 for APC 8006 and $315.59 for the undisputed CPT codes, for a total of $4,181.93, a reimbursement amount that complies with 28 Texas Administrative Code § 134.403(f).

ORDER

Carrier is to pay Provider an additional $2,708.72 for Provider's treatment of Claimant on _____.

ISSUED March 4, 2013.

Sharon Cloninger

SHARON CLONINGER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS