SOAH DOCKET NO. 453-04-5394.M4
TWCC NO. M4-03-1358-01

VISTA MEDICAL CENTER HOSPITAL,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
TEXAS MUTUAL INSURANCE CO.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

In a decision dated March 23, 2004, the Medical Review Division (MRD) of the Texas Workers' Compensation Commission[1] (Commission) denied the request for additional reimbursement filed by Vista Medical Center Hospital (Vista) for services it provided to a workers' compensation claimant during an inpatient hospital admission.

MRD first determined that Texas Mutual Insurance Company (TMIC) improperly carved out the charges for implantables and reimbursed Vista for them at the rate of cost plus 10%. MRD said that if the charges appeared to be inflated, the Carrier should have determined the usual and customary charges billed by other facilities for implantables in the same geographical region as Vista. Not unless other facilities charged cost plus 10% for implantables could the Carriers establish that amount as a usual and customary charge, MRD concluded. However, because Vista did not dispute certain aspects of the payments and did not provide medical information to refute TMIC's denial reasons as listed on the explanations of benefits, MRD recommended no additional reimbursement.

In the appeal, the parties submitted the case based on joint stipulations and asked that the decision address both the appropriateness of auditing implant charges at cost plus 10% and the issue of whether services provided were unusually costly and extensive.

1 Effective September 1, 2005, the functions of the Commission were transferred to the newly-created Division of Workers' Compensation at the Texas Department of Insurance.

In this decision, the Administrative Law Judge (ALJ) finds that:

- TMIC audited and then properly paid Vista's charges for surgical implantables at the rate of Vista's cost plus 10%;
- after the charges for implantables were audited and reimbursed at that rate, the total inpatient-surgical-admission charges were less than $40,000;
- based on the fact that total charges were less than $40,000, the *per diem* method is the appropriate method to use for reimbursement; and
- it is unnecessary to reach the issue of whether the inpatient admission involved unusually extensive services.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

The parties participated in a preliminary hearing to resolve threshold legal issues for this docket and twelve others,[2] and on November 22, 2005, the ALJ issued an order addressing those issues. The ALJ also advised the parties to consult and agree upon proposed hearing dates for the hearings on the merits. The parties then requested that this case be decided based on their stipulations and briefs. The briefing record closed on March 10, 2006.

In this case, attorneys Thomas B. Hudson, Jr. and Christopher H. Trickey represented TMIC, and attorney David F. Bragg represented Vista. After assuring the ALJ that the claimant's name and other identifying information had not been disclosed to them, two insurer groups were allowed to intervene in this case: Hartford Underwriters Insurance Company (Hartford), represented by attorney James M. Loughlin; and Indemnity Insurance Company of North America, Healthcare Corporation/ESIS, and ACE USA/ESIS/Pacific Employers Insurance Company (IICNA), represented by attorney John Pringle. IICNA filed an argument, and Hartford joined in the closing statement filed by TMIC.

II. DISCUSSION

In Order No. 14 in the consolidated docket, the ALJ concluded that in auditing to determine whether "total audited charges" exceed $40,000, a carrier may reduce the provider's billed charges for items covered by 28 TEX. ADMIN. CODE ANN. (TAC) §134.401(c)(4)(A)[3] (regarding

2 Docket No. 453-03-2412.M4. The order was issued November 22, 2005.

3 Pertinent portions of the rule are included in this Decision as Attachment A.

implantables) to the provider's cost plus 10% in order to calculate whether a bill exceeds the stop-loss threshold.

Vista charged $15,992 for the implants. In its audit, TMIC changed the amount for implants to $1,718.20, the cost of the implants plus 10%. After TMIC's audit and reduction for the implantables, the total audited charges for the claimant's surgical admission did not exceed $40,000.

TMIC and the interventors argued that the stop-loss exception is not applicable to a hospital's payment claims under the 1997 Hospital Fee Guideline (1997 HFG) unless both of two criteria are met: (1) total audited charges exceed $40,000; and (2) required services rendered during the admission are unusually extensive. If either of the criteria is not met, the admission should be paid under the 1997 HFG's *per diem* rate with additions for appropriate items, they asserted.

Also, the insurers contended, since the total audited charges do not exceed $40,000, the stop-loss exception does not apply to Vista's payment claims. In TMIC's view, the case turns on the meaning of unusually extensive services. If the term means unusually extensive in comparison with services rendered in other admissions of the same type, then the services are not unusually extensive. But if unusually extensive services mean that a complex back surgery is, by definition, unusually extensive compared with a hernia repair, then the services in this case were unusually extensive, TMIC argued.

In addition, in TMIC's opinion, determinations about whether services required during an admission are unusually extensive and unusually costly should be made on a case-by-case basis and by comparing the services and costs in the disputed admission with the services and costs associated with similar kinds of inpatient hospital admissions, not by comparing surgeries at the extremes of the workers' compensation system surgical spectrum. Vista had to prove both that the total audited charges exceeded $40,000 and the admission involved unusually extensive services on a case-by-case, not category, basis in order to qualify for stop-loss reimbursement. In this case, Vista met neither test, TMIC concluded.

Vista argued that the ALJ erred in finding a carrier may reduce charges for implants to cost plus 10% in order to determine whether stop-loss reimbursement applies. However, assuming the ALJ is not inclined to change that ruling; Vista agreed that the second issue, *i.e.*, whether the charges were unusually extensive, is not reached.

But, Vista contended, once the stop-loss threshold of $40,000, is reached, the inpatient hospitalization should not be examined to determine whether the services were unusually extensive. Vista cited the Commission's definition of the stop-loss threshold in support of its argument. The definition characterizes the stop-loss threshold established by the Commission ($40,000 for an inpatient admission) as the amount beyond which reimbursement is calculated by multiplying the applicable stop-loss reimbursement factor (75%) by the total charges identifying that particular threshold.[4]

III. ANALYSIS

A portion of the order on threshold legal issues is included in this Decision as Attachment B.[5] In that order, the ALJ determined that a carrier is allowed to audit a hospital's total charges and to reduce the amounts charged for implantables to cost plus 10%. Under the stipulated facts in this case, TMIC audited and then paid Vista's charges for surgical implantables at the rate of Vista's cost plus 10%. With that change and other stipulated changes in Vista's charges, Vista's total charge for the inpatient admission was less than $40,000.

To be eligible for stop-loss reimbursement, *i.e.*, reimbursement calculated as 75% of the total charge, the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold.[6] It is unnecessary to reach the issue of whether the inpatient admission involved unusually extensive services unless the total charges exceed $40,000.

Because Vista's charges were less than $40,000, Vista does not qualify for stop loss payment; instead, the Commission's rule provides that payment will be made based on *per diem* rates with additional reimbursement provided for implantables. TMIC paid Vista $6,190.20 for the inpatient services calculated as four days times the *per diem* reimbursement rate, and cost plus 10% for the implantables: (4 x $1,118) + ($1,562 x 1.1) = $6,190.20. The amount was the appropriate reimbursement based on determinations made on the threshold legal issues. Therefore, the ALJ recommends no additional reimbursement for Vista.

---

4 28 TAC 134.401(b)(1)(H) and (c)(6)(A)(i).

5 The ALJ made slight editing changes to correct typographical errors in the original.

6 28 TAC § 134.401 (c)(6)(A)(i).

IV. FINDINGS OF FACT

1. In a decision dated March 23, 2004, the Medical Review Division of the Texas Workers' Compensation Commission (the Commission) denied the request for additional reimbursement from Texas Mutual Insurance Company (TMIC) filed by Vista Medical Center Hospital (Vista) for services it provided to a workers' compensation claimant (claimant) during an inpatient hospital admission.

2. Notice of the hearing, dated May 20, 2004, was sent to the Vista and TMIC.

3. 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.

4. After the parties participated in a preliminary hearing to resolve threshold legal issues for this docket and twelve others, the ALJ issued a decision on November 22, 2005. The ALJ also advised the parties to consult and agree upon proposed hearing dates for the hearings on the merits.

5. The parties requested that the case be decided based on their stipulations and briefs. In accordance with Order No. 2, which was sent to all parties, the briefing record closed on March 10, 2006.

6. Attorneys Thomas B. Hudson, Jr., and Christopher H. Trickey represented TMIC, and attorney David F. Bragg represented Vista.

7. Two insurer groups were allowed to intervene in this case: Hartford Underwriters Insurance Company (Hartford), represented by attorney James M. Loughlin; and Indemnity Insurance Company of North America, Healthcare Corporation/ESIS, and ACE USA/ESIS/Pacific Employers Insurance Company (IICNA), represented by attorney John Pringle.

8. The claimant was injured while working for an employer who carried workers' compensation insurance with Texas Mutual Insurance Company (TMIC).

9. The compensability of the claimant's injury was not disputed.

10. On February 21, 2002, the claimant was admitted to Vista Medical Center Hospital and underwent back surgery to treat his work-related injury.

11. The procedure performed on the claimant was an anterior cervical fusion at the C6-7 vertebrae; the disc between vertebrae C6 and C7 was removed and replaced with allograft bone.

12. To stabilize the bone graft, a cervical plate was implanted in the claimant and was connected to the vertebrae using cervical screws.

13. The claimant experienced minimal blood loss during the surgery and tolerated the procedure well.

14. The surgeon noted no complications, and the claimant was transferred to the recovery room in satisfactory condition.

15. Nothing unexpected or unusual occurred during either the surgery or the subsequent hospitalization.

16. The claimant was discharged from Vista on February 25, 2002.

17. The claimant's admission was a four-day surgical admission.

18. Vista charged $57,063.15 for the services rendered to claimant from February 21-25, 2002.

19. Vista charged $15,992 for the surgical implants.

20. The cost to Vista of the implants was $1,562.

21. In its audit, TMIC reduced the charges for implants to $1,718.20, which is the stipulated cost of such implants, plus 10%.

22. Vista has withdrawn its request for reimbursement for charges for video of the surgery ($1,836) and anesthesia equipment ($1,500).

23. With the stipulated adjustments and the change for implant reimbursement, the total audited charges are $39,453.35 (57,063.15 - [1,836 + 1,500 + 15,992] +1,718.20 = $39,453.35).

24. After TMIC reduced the charge for implants, Vista's remaining charges for the hospitalization totaled less than $40,000.

25. The workers' compensation standard per *diem* amount to be used in calculating the reimbursement for acute care inpatient services is $1,118 for a surgical admission. 28 TAC § 134.401(c)(1).

26. TMIC paid Vista $6,190.20 for the inpatient services rendered to claimant from February 21-25, 2002, calculated as (4 x $1,118) + ($1,562 x 1.1) = $6,190.22.

27. The amounts Vista billed were its usual and customary charges.

28. For purposes of this case only, Vista did not contest the adequacy of TMIC's denial codes or explanations, and TMIC did not contest the adequacy of Vista' documentation to support its charges.

V. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to § 413.031 of the Texas Workers§ Compensation Act, TEX. LAB. CODE ANN. ch. 401 *et seq*. (Vernon's 2004).

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003 (Vernon's 2004).

3. When medically necessary, surgical implantables (revenue codes 275, 276, and 278), shall be reimbursed at cost to the hospital plus 10%. 28 TEX. ADMIN. CODE ANN. (TAC) § 134.401(c)(4)(A).

4. TMIC's reduction of Vista's charges for implants to $1,718.20, the cost of the implants, plus 10% was appropriate.

5. Pursuant to the Commission's 1997 Hospital Fee Guideline, an acute care hospital is to be reimbursed for medical and surgical admissions using a service-related standard per *diem* amount. 28 TAC §134.401(c)(2).

6. Independent reimbursement for an admission is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold. 28 TAC § 134.401 (c)(2)(C).

7. The stop-loss method is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. This methodology must be used in place of and not in addition to the *per diem* based reimbursement system. 28 TAC § 134.401 (c)(6).

8. To be eligible for stop-loss reimbursement, the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold. 28 TAC § 134.401 (c)(6)(A)(i).

9. Payment of the *per diem* rate, together with the cost plus 10% for implantables, is appropriate because total audited charges did not exceed $40,000.

10. TMIC appropriately reimbursed Vista for charges related to the claimant's hospitalization.

ORDER

IT IS THEREFORE, ORDERED that Vista Medical Center Hospital's request for additional reimbursement in this case is denied**.**

SIGNED May 9, 2006.

SARAH G. RAMOS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

ATTACHMENT A
28 TEX. ADMIN. CODE § 134.401(c)

(c) Reimbursement.

(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: . . . SurgicalB$1,118 . . .

(2) Method. 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.

. . .

(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

. . .

(3) Reimbursement Calculation.

(A) Explanation.

(i) Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical).

(ii) The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission.

. . .

(iv) The Workers' Compensation Reimbursement Amount (WCRA) is the total amount of reimbursement to be made for that particular admission.

(B) Formula. LOS x SPDA = WCRA.

. . .

(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 . . . and
(ii) Orthotics and prosthetics . . .
. . .

(B) When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate:

(i) Magnetic Resonance Imaging (MRIs) . . . ;
(ii) Computerized Axial Tomography (CAT scans) . . . ;
(iii) Hyperbaric oxygen . . . ;
(iv) Blood . . . ; and
(v) Air ambulance . . . .

(C) Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time. . . .

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

ATTACHMENT B
EXCERPT FROM ORDER NO. 14
IN CONSOLIDATED DOCKET NO. 453-03-2412.M4

2. In auditing to determine whether "total audited charges" exceed $40,000, may the carrier reduce the provider's billed charges for items covered by 28 TAC § 134.401(c)(4)(A) and (C) to the provider's cost plus 10%?

In five of the cases that were consolidated into Docket No. 453-03-2412.M4 for resolution of threshold legal issues, MRD determined that the Carriers improperly carved out the charge for implantables and reimbursed Vista for them at the rate of cost plus 10%.[7] MRD said that if the charges appeared to be inflated, the Carriers should have determined the usual and customary charges billed by other facilities for implantables in the same geographical region as Vista. Not unless other facilities charged cost plus 10% for implantables could the Carriers establish that amount as a usual and customary charge, MRD concluded.[8]

1. Vista's Arguments

Vista argued that the Guideline clearly separates the reimbursement methodologies, and the reimbursement method of cost plus 10% for implantables and pharmaceuticals applies only when the *per diem* reimbursement method is used. The Commission's staff addressed this issue with an answer in its resolution log that instructed carriers not to confuse the carve-out items identified in 28 TAC §134.401(c)(4) as items that can be deducted in an audit or paid separately when a provider's charges exceed $40,000. Instead, the charges should be paid using the stop-loss method of 75% times the charges. Further, Vista notes, when providers are paid under the stop-loss provision at 75% of their total charges, they will be reimbursed less than their actual costs if implantables are billed at cost plus 10%.

1. Carriers' Arguments

According to the Carriers, effective medical cost control cannot be achieved unless implantables are billed at cost plus 10% regardless of whether stop loss or *per diem* applies. Moreover, the Carriers argued, the Commission itself has never taken an official position on whether carriers may reduce charges for implantables to cost plus 10%. At times, staff members have instructed carriers to reduce the charges during audits to those amounts. The Carriers also relied on SOAH decisions that determined the cost for implantables should be counted as cost plus 10% for the purpose of determining whether the stop-loss method applies.

7 Docket Nos. 453-04-5394.M4, 453-03-2412.M4, 453-04-8356.M4, 453-04-4014.M4, and 453-03-2109.M4.

8 Docket Nos. 453-04-5394.M4, 453-03-2412.M4, 453-04-4014.M4, and 453-03-2109.M4.

2. ALJ's Ruling

Some medical dispute resolution officers and ALJs have found that implantables should be calculated at cost plus 10% to determine whether the total charges exceed $40,000. Otherwise, hospitals could determine their preferred level of reimbursement, either stop loss or per *diem*, simply by doing the math and pricing implantables at a level so that total charges exceed $40,000. ALJ Cunningham found this practice would be a disincentive for hospitals to contain costs and would defeat the statutory objective of effective cost control, and she concluded that a carrier should be allowed to reduce charges for implantables to cost plus 10%.[9] Similarly, both ALJs Elkins and Seitzman have found that surgical implantables are excepted from stop-loss, and, when medically necessary, are to be calculated at cost plus 10%.[10]

On the other hand, ALJ Walston determined the subsection allowing additional reimbursement for implantables at cost plus 10% is a part only of the *per diem* reimbursement methodology and is not a proper audit item to determine which methodology applies. In other words, he found that implantables were to be reimbursed at cost plus 10% when the total charges were less than $40,000; but when charges exceeded $40,000, implantables should be reimbursed at the hospital's usual and customary rate, regardless of the cost.[11] However, ALJ Walston also noted that in his case, the insurer had the burden of proof but offered no evidence that the prices billed for implantables were not the hospital's usual and customary charges, the price markup was unreasonable, or the final price was not fair and reasonable. In contrast, the hospital's evidence proved the implantables were billed at the usual and customary rate, all patients were billed the same price for these items, and the price markup was used to cover various overhead costs.[12] Thus, ALJ Walston implied that he may have reached a different conclusion if the carrier had presented convincing evidence to support its arguments.

The manner in which the Guideline's reimbursement section is organized is confusing. Some MRD officers and ALJs have considered paragraph (c) (4) as an introduction to paragraph (c)(4)(A).

---

9 Docket No. 453-00-2092.M4; *see also* Docket No. 453-03-1626.M4, in which ALJ Harvel reached a similar result.

10 Docket Nos. 453-04-4455.M4 and 453-03-3120.M4.

11 ALJs Card and Church have reached similar conclusions. Docket Nos. 453-04-4223.M4 and 453-04-3600.M4.

12 Docket No. 453-03-1233.M4.

Because paragraph (c)(4)(A) is preceded by the paragraph that describes *when* additional reimbursement is available for implantables, *i.e.*, when the *per diem* method applies, it is an understandable interpretation to say the *method* of cost plus 10% for calculating the cost of implantables should be used only when the audited charges are less than $40,000, and *per diem* reimbursement applies. But paragraph (c)(4)(A) itself is not written as a conditional statement. It is written as inclusive and requires only medical necessity as a condition to reimbursement at cost plus 10%. The paragraph does not separate the cost plus 10% amount to use for calculating the cost of implantables based on whether the *per diem* or stop-loss reimbursement method applies.

Since the rule is not clear, it is appropriate to seek guidance from Code Construction Act. Although that Act applies to construction of codified statutes, it can provide guidance, by analogy, for legally interpreting the rules. That Act provides that in construing a statute, whether or not the statute is considered ambiguous on its face, a court may consider among other matters the: (1) object sought to be attained; (2) circumstances under which the statute was enacted; (3) legislative history; (4) common law or former statutory provisions, including laws on the same or similar subject; (5) consequences of a particular construction; (6) administrative construction of the statute; and (7) title (caption), preamble, and emergency provision.[13]

In the Guideline's preamble, the Commission said it sought to balance several factors when it adopted the Guideline: quality care for claimants, fair and reasonable reimbursements, effective medical-cost control, fees in line with what similarly-situated consumers were charged, and the security afforded when payment would be made according to the Act.[14] Thus, the object sought to be obtained was not a single one, but it included many aspects.

Another Code Construction Act principle is to consider the consequences of a particular construction. The Commission determined that a cost-based reimbursement system would leave the ultimate reimbursement in the control of the hospital, defeating the statutory objective of effective cost control.[15] As stated in the Commission's preamble:

[C]harges are not a valid indicator of a hospital's costs of providing services. . . .

13 TEX. GOV'T CODE ANN. § 311.023.

14 22 *Tex. Reg.* 6265 (1997).

15 *Id.* at 6276.

> Therefore, under a so-called cost-based system, a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control. . . .[16]

The Commission also rejected the discount-from-billed-charges methodology because it left the ultimate reimbursement in the control of the hospital and provided no incentive to control costs.[17]

Further, as ALJ Cunningham noted, the Commission analyzed a large number of 1994-1995 hospital contracts to "carve out of" the *per diem* rates the highest cost services and supplies based on managed-care contracts. The services were identified by diagnostic codes, and supplies and equipment were identified by revenue codes. Implantables were included in the revenue code carve outs.

The Commission chose the 10% addition because it was used in the 1992 Guideline, and was based on the recommendation of the Medical Advisory Committee that it would assure a reasonable return for the hospitals. According to the Commission:

> [C]ommenters did not oppose the 10% add-on, and the Commission has no data or information which would indicate that 10% is inadequate or excessive.[18]

In the preamble, the Commission also noted it had increased the *per diem* reimbursement for surgical admissions from the amount authorized in the 1992 Guideline. The Commission expected that the increase would give "injured workers access to acute care inpatient services and serve as an additional protection to ensure fair and reasonable rates."[19] Similarly, adjusting the rate for implantables to the hospital's cost plus 10% would ensure that the cost of the item and related overhead costs were covered.

---

16 *Id.* at 6297.

17 *Id*. at 6276.

18 *Id*.

19 *Id.* at 6268.

Based on this guidance and the consequences of cost-based reimbursement, the ALJ concludes that a carrier should be allowed to reduce charges for implantables to cost plus 10% to calculate whether a bill exceeds the stop-loss threshold. This view is more in line with the Commission's comments addressing effective cost control and a reasonable return for hospitals.