SOAH DOCKET NO. 453-99-0533.M4HD

RE:	**§**	**BEFORE THE STATE OFFICE**
HOSPITAL FEE	**§**	**OF**
GUIDELINE DISPUTES	**§**	**ADMINISTRATIVE HEARINGS**

SOAH DOCKET NO. 453-99-0355.M4HD

SIERRA MEDICAL CENTER	**§**	**BEFORE THE STATE OFFICE**
V.	**§**	**OF**
CONTINENTAL CASUALTY CO.	**§**	**ADMINISTRATIVE HEARINGS**

SOAH DOCKET NO. 453-99-0643.M4HD

COLUMBIA EAST HOUSTON	**§**	**BEFORE THE STATE OFFICE**
MEDICAL CENTER	**§**	
V.	**§**	**OF**
TEXAS WORKERS' COMPENSATION	**§**	
INSURANCE FUND	**§**	**ADMINISTRATIVE HEARINGS**

SOAH DOCKET NO. 453-99-1677.M4HD

COLUMBIA SOUTHWEST TEXAS	**§**	**BEFORE THE STATE OFFICE**
METHODIST HOSPITAL	**§**	**OF**
V.	**§**	
LIBERTY MUTUAL INSURANCE CO.	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This decision addresses whether additional reimbursement is warranted for medical services provided between September 1, 1992, and February 13, 1997, that have already been reimbursed at levels set under the void 1992 Acute Care Hospital Fee Guideline (the 1992 Guideline) adopted by the Texas Workers' Compensation Commission (the Commission). The Administrative Law Judge (ALJ) finds the Petitioners, various hospitals (the Hospitals), failed to prove that the amounts reimbursed to them under the 1992 Guideline were unfair or unreasonable and that, in general, they were entitled to any additional reimbursement.

The ALJ concludes that the Hospitals might be entitled to additional reimbursement if there were contracts between them and the Respondents, various workers' compensation carriers (the Carriers), governing payment for workers' compensation services. In the individual test cases, however, the Hospitals failed to prove the existence of such contracts.

The Hospitals proved that in the test cases they were not reimbursed for implantable hardware used in orthopedic surgery (implantables). The ALJ finds a fair and reasonable reimbursement rate for implantables was cost plus ten percent. In two of the test cases, however, the Hospitals provided no evidence on the cost of the implantables. In those cases, the ALJ orders no additional reimbursement for those items. In the third case, *Columbia Southwest Texas Methodist Hospital v. Liberty Mutual Insurance Company*, the ALJ orders additional reimbursement of $4,218.50, which is cost of the implantables plus ten percent.

The ALJ also concludes neither the State Office of Administrative Hearings (SOAH) nor the Texas Department of Insurance, Department of Workers' Compensation (DWC)[1] has authority to order payment of prejudgment interest on additional reimbursements for periods during which no Commission fee guideline was in place.

I.JURISDICTION AND NOTICE

SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §413.031(Vernon 1996) and TEX. GOV'T CODE ANN. ch. 2003. The parties received timely and adequate notice of the hearing. There was no challenge to either jurisdiction or the adequacy of notice.

II.PROCEDURAL HISTORY

In 1989, the Texas Legislature made significant changes to the Texas Workers' Compensation Act (the Act).[2] Under the revised Act, the Commission was required to establish fee guidelines. The legislation required the guidelines to be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.

The guidelines may not provide for payment of a fee in excess of the fee charged for similar

[1] The DWC assumed the functions of the Commission on September 1, 2005. Generally in this Decision, the ALJ will refer to "the Commission" unless the distinction between the two agencies needs to be made.

[2] Much of this procedural summary is paraphrased from various Court of Appeals opinions in this lengthy dispute.

treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf.

The statute required the Commission to consider "the increased security of payment afforded by this subtitle" in establishing the fee guidelines. TEX. LAB. CODE ANN. § 413.011(d).

On December 21, 1990, the Commission adopted an emergency fee guideline, which took effect January 1, 1991, and expired June 30, 1991 (the 1991 Emergency Guideline). Under that guideline, carriers were to reimburse hospitals based on a fixed percentage of each hospital's stated charges for services. No guideline was in place from June 30, 1991, until September 1, 1992, when the 1992 Guideline took effect. The 1992 Guideline took a very different approach to reimbursement, dividing medical services into categories, *e.g.* surgical and intensive care, and setting a *per diem* reimbursement rate for each category.[3]

Several hospitals challenged the 1992 Guideline in court. In December of 1995, the Court of Appeals invalidated the 1992 Guideline, declaring it void and unenforceable for lack of an adequate reasoned justification.[4] The Commission appealed that decision to the Texas Supreme Court, which denied the writ on February 13, 1997. Effective August 1, 1997, the Commission adopted another fee guideline (the 1997 Guideline), which also used the *per diem* method of reimbursement, although it differed from its predecessor in some respects.[5]

Although the 1992 Guideline had been declared void, many carriers continued reimbursing hospitals until August 1, 1997, at the levels set in that Guideline. The Commission did not require a different level of reimbursement. Because of the ongoing lawsuit and the Court of Appeals' decision, many of the hospitals did not file requests for dispute resolution seeking additional payments within the one-year deadline set in the Commission's rule at 28 TEX. ADMIN. CODE (TAC) § 133.305(a).[6]

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[3] Obviously, the entire reimbursement scheme established by the 1992 Guideline is more complicated than set forth in this summary.

[4] *Texas Hospital Ass'n v. Texas Workers' Compensation Comm'n*, 911 S.W. 2d 884 (Tex. App.-Austin 1995, writ denied).

[5] Although some hospitals initially challenged the 1997 Guideline, they later abandoned that suit.

[6] The filing deadline is now found at 28 TAC § 133.307(d).

The "one-year rule" provided:

> (a) A request for review of medical services and dispute resolution . . . shall be submitted to the commission . . . no later than one calendar year after the dates of service in dispute.

On February 24, 1997, the Commission's Executive Director issued a memorandum stating the Commission would not consider requests for dispute resolution pertaining to the 1992 Guideline that had not been timely filed under the one-year rule. The Texas Hospital Association and certain hospitals sued the Commission regarding that policy. In July of 1997, those parties entered into a Compromise Settlement Agreement (the CSA). Under the CSA, the Commission agreed it would accept and process requests for dispute resolution from hospitals until August 15, 1998, for services provided between September 1, 1992, and February 14, 1997, if the requests for reimbursement were based on the statutory criteria set out in TEX. LAB. CODE ANN. § 413.011(b) and on the fact that the 1992 Guideline had been declared invalid by the courts.

The generally accepted estimate of the parties is that hospitals filed more than 20,000 claims at the Commission requesting reimbursement on the basis that payments made under the 1992 Guideline were not fair and reasonable. After the CSA deadline passed, the Commission began issuing decisions in the individual cases before it. In each instance in which a decision was issued, the Commission found the hospital had failed to provide sufficient documentation to support additional reimbursement. The hospitals filed timely requests for hearing in those cases, which then were referred to the State Office of Administrative Hearings (SOAH).[7]

At SOAH, a joint prehearing conference was held on March 19, 1999, in thirteen of the hospital requests. The threshold procedural and legal issues in those cases, and eventually other cases involving the 1992 Guideline, were consolidated into Docket No. 453-99-0533.M4HD, *Re: Hospital Fee Guideline Disputes*. Order No. 4 set out the threshold legal issues to be briefed by the parties. In Order No. 6, issued in December of 1999, the undersigned ALJ decided those issues:

> The ALJ concludes the Court of Appeals' decision in *Texas Hospital Ass'n v. Texas Workers' Compensation Commission*, 911 S.W.2d 884 (Tex. App. - Austin 1995, writ denied) (*THA v. TWCC*) has retroactive application, in the sense that it applies to all claims submitted and paid under the Commission's 1992 Acute Care Inpatient Hospital Fee Guideline (the 1992 Guideline). The standard that governs those claims is TEX. LAB. CODE §413.011 (Vernon 1996), not the Commission's previous Guideline or the parties' practices before the 1992 Guideline took effect.

[7] More than two hundred 1992 Guideline cases were referred to SOAH before the Commission agreed to stop issuing decisions to allow the issues to be determined at hearing. The cases that were not decided by the Commission were transferred to DWC on September 1, 2005, with other functions of the Commission.

> The ALJ further concludes the stop/loss provision of the 1992 Guideline does not apply to the pending claims, and rejects the argument that the claims are barred by the doctrine of *res judicata.*
>
> The ALJ also concludes TWCC Rule 133.305 does not require the dismissal of disputes based solely on the 1992 Guideline that were not filed with TWCC within one year of the date the hospital services were provided. Finally, the burden of proof in these cases is on the party appealing TWCC's decision. In all the cases of which the ALJ is aware, that party is the Hospitals.

Two of the rulings in Order No. 6 were challenged in district court. The Carriers challenged the ALJ's ruling on TWCC Rule 133.305 (the one-year rule). The Austin Court of Appeals eventually overturned the ALJ's decision on that issue. *Hospitals v. Continental Cas. Co.*, 109 S.W.3d 96 (Tex. App.-Austin 2003, pet. denied). The Hospitals challenged the ALJ's ruling on the legal standard that governs these claims. The Court of Appeals eventually upheld the ALJ's decision on that issue. *All Saints Health Sys. v. Texas Workers' Comp. Comm'n*, 125 S.W.3d 96 (Tex. App.-Austin 2003, pet. denied). Both those opinions are discussed in more detail later in this decision. None of the other rulings in Order No. 6 were challenged in court.

After issuing Order No. 6 and considering suggestions from the parties, the ALJ established a procedure under which several of the individual cases would be designated as "test cases" to proceed to hearing. Order No. 10, issued in September 2000, designated five test cases.[8] The Hospitals filed written direct testimony and exhibits, and the cases were referred, unsuccessfully, to mediation. The cases then proceeded to discovery by the Carriers, which was characterized by a number of complicated and vigorously contested disputes, primarily concerning the discoverability of managed care contracts.

In February of 2002, after an order resolving pending discovery disputes, the Hospitals moved for abatement of the SOAH proceedings. The Carriers previously had filed their action in district court challenging the ALJ's decision about applicability of the one-year rule. The motion for abatement stated the Hospitals had filed their own request for affirmative relief in that case. That request challenged the ALJ's ruling on the legal standard governing the claims and sought a determination that the percentage-of-billed-charges approach that preceded the 1992 Guideline

[8] Only one of those original test cases remains, due to the Court of Appeals' subsequent decision on the one-year-rule issue.

should be adopted as the appropriate standard for payment.[9] The ALJ denied the motion for abatement on April 9, 2002. However, he indicated he might reassess that decision depending on the status of the district court proceedings.

On August 9, 2002, after the district court ruled in the Carriers' favor on the one-year-rule issue, the Hospitals filed a second motion for abatement. On August 21, 2002, the ALJ granted the motion and stayed these proceedings.

In 2004, the Texas Supreme Court denied the petitions for review in *Hospitals v. Continental Cas. Co.* and *All Saints*. *Hospitals v. Continental Cas. Co.* precluded hospitals from pursuing the many claims that had been filed more than one year after the date of the disputed services. The Hospitals undertook the task of determining which of the pending SOAH cases had been filed more than one year after the disputed service dates, and provided that information to the ALJ. In Joint Orders Nos. 19 and 22, the ALJ dismissed more than 150 of those cases, including four of the five test cases. In Joint Order No. 21, the ALJ designated four new test cases to join the one remaining original case. Two of those eventually were dismissed-one due to settlement and one because the Hospital could no longer find the applicable records-leaving the three test cases that are partly the subject of this decision.[10]

After the filing of additional testimony, discovery, and a further continuance, the hearing in these cases was finally convened June 12, 2006. The hearing was adjourned June 21, 2006. The parties' initial written closing arguments were filed on August 25, 2006, and reply arguments on September 25, 2006, when the record was closed.

III. DISCUSSION

A. The meaning of *All Saints*

Order No. 6 addressed, among other things, the Hospitals' contention that these cases were governed either by the 1991 Emergency Guideline or by the Commission's practice after that Guideline expired and before the 1992 Guideline was adopted. Because the Commission had continued the reimbursement practices set out in the 1991 Guideline, the practical effect of the two arguments would be the same-the Hospitals would be entitled to reimbursement at a fixed percentage of each hospital's stated prices for services. The ALJ rejected that argument. He

[9] The district court severed the Hospitals' claim, which became *All Saints*, from the Carriers', which became *Hospitals v. Continental Casualty Co.*

[10] At the time of this decision, 67 cases involving the 1992 Guideline remain at SOAH.

concluded that the Commission's rule at 28 TEX. ADMIN. CODE § 134.1 required services not identified in an established fee guideline to be reimbursed at "fair and reasonable rates" as required by TEX. LAB. CODE ANN. § 413.011.

In *All Saints*, the Hospitals challenged that ALJ decision. The district court granted the Defendant Carriers' motion for summary judgment and the Court of Appeals affirmed the district court's decision. The Court explicitly rejected the Hospitals' contention that they were entitled to reimbursement at the levels set in the 1991 Emergency Guideline or the similar practices that followed its expiration. Instead, the Court agreed with the ALJ and the Carriers that hospital reimbursement should be determined according to Section 413.011(d)'s definition of "fair and reasonable." 125 S.W.3d at 103-04.

The Court went beyond that determination, however. First, it rejected the notion that contemporaneous managed care contracts *per se* set a cap on reimbursement, although it recognized that such contracts may be evidence of the fair and reasonable amount. Second, the Court clarified its *Texas Hosp. Ass'n* decision that voided the 1992 Guideline. The Court stated it had invalidated not only the guideline itself, but also the new policy, embodied in the 1992 Guideline, of reimbursing claims on a *per diem* basis. In this case, the Court said, the Hospitals' "fair and reasonable" reimbursements must be predicated on a fee-for-service model rather than a per diem basis.
125 S.W.3d at 106.

Not surprisingly, the parties disagreed about the meaning and significance of that portion of the Court's opinion. The Hospitals argued that under the Court's ruling, SOAH may consider only managed care contracts that provide for payment of a percentage of the Hospitals' charges and must ignore any managed care contracts that provided for payment on a *per diem* basis.[11] The Carriers argued that the portion of the opinion that rejected *per diem* reimbursement was mere *dicta* and was based on misunderstandings of SOAH's previous rulings and the Carriers' arguments.

The Carriers also argued that the term "fee-for-service," as used by the Court, included the *per diem* methodology.[12]

[11] Hospital's Initial Brief at p. 18.

[12] Carrier's Reply Brief at pp. 10-13.

The ALJ does not agree entirely with either party on the meaning of *All Saints*. He agrees with the Hospitals that the Court's rejection of a *per diem* reimbursement scheme was not *dicta*. It was part of the Court's holding in the case. The Court said so in the opinion itself, and said so again when it rejected the Carriers' motion for rehearing. The ALJ agrees with the Carriers, however, that all managed care contracts may be considered as relevant evidence in determining what reimbursement level is fair and reasonable under the Labor Code. The Court acknowledged the relevance of the managed care contracts. It did not make any distinction between the types of contract, even as it ruled they were not *per se* determinative. Most importantly, the Court did not rule that the amounts paid by the Carriers were unfairly or unreasonably low merely because they were calculated on a *per diem* basis.

In this case, the Hospitals have the burden of proving, by a preponderance of the evidence, what level of reimbursement is fair and reasonable under TEX. LAB. CODE ANN. § 413.011(d). To phrase it more practically, the Hospitals must prove they are entitled to additional reimbursement and the amount of that additional reimbursement.[13] As the ALJ interprets *All Saints*, he must use a percentage-of-billed charges approach in making that determination. In other words, the Hospitals' burden is to prove they should be paid a higher percentage of their billed charges than was actually paid by carriers under the 1992 Guideline reimbursement scheme.

In making that determination, the ALJ may examine the Hospitals' costs, the percentages of billed charges paid under Medicare and the Hospitals' managed care contracts, the quality of care provided and any other evidence provided by the parties that relates to the statutory standards set out in TEX. LAB. CODE ANN. § 413.011.

B. The statutory standard

The language of TEX. LAB. CODE ANN. § 413.011 is set forth above in this decision. Under that section, fees:

(1) must be fair and reasonable;
(2) must be designed to ensure the quality of medical care;
(3) must be designed to achieve effective medical cost control;
(4) may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf; and
(5) must consider the increased security of payment afforded by the Labor Code.

[13] 125 S.W.3d at 104; Order No. 6.

C. Evidence and analysis

1. General fair and reasonable reimbursement levels

a. Evidence presented

The Hospitals' primary witnesses on the issue of what level of reimbursement generally was fair and reasonable were George Berry, Ph.D. and___.[14]

Dr. Berry expressed the opinion that the charges submitted by hospitals are generally accepted by carriers as fair and reasonable.[15] He testified that a statewide fee schedule was inherently unreasonable. He objected to any attempt to compare workers' compensation claimants to any other group (*e.g.* Medicare patients) because groups obviously differ in income and age. In particular, he objected to the conclusions reached by Carrier witness Ron Luke, Ph.D., that workers' compensation patients have an equivalent standard of living to Medicare and managed care patients within the meaning of TEX. LAB. CODE ANN. § 413.011.[16] He further objected to Dr. Luke's conclusion that workers' compensation rates need only be set at levels adequate to recover hospitals' variable costs.

Dr. Berry asserted that the nonelderly have substantially higher levels of real income compared to the elderly and other persons covered by Medicare. He provided a survey of consumer finances from the Federal Reserve Board to support that observation.

Dr. Berry did not discuss any differences in the standard of living between workers' compensation and managed care patients. He pointed out, however, as had Dr. Luke, that approximately 75 percent of the commercially insured population were under some kind of managed care, while workers' compensation patients accounted for only 3 percent of hospital discharges.

In Dr. Berry's view, "It is illogical that a small segment of the total market should have the ability to set rates on a predatory basis-those equal to or less than marginal costs."[17] As other differences between workers' compensation and managed care, Dr. Berry cited the ability of

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[14] Although Larry Wallace also provided some testimony for the Hospitals, he mostly addressed the reimbursements provided by carriers for services provided before the 1992 Guideline. Mr. Wallace acknowledged he was not an expert on economics, accounting, or hospital costs or revenues. Pet. Ex. 21; Tr. at 647-49. Portions of Mr. Wallace's offered testimony were excluded. See Tr. at 497-512.

[15] Dr. Berry's testimony was admitted as Pet. Exs. 32A-D.

[16] Dr. Luke made that assertion to show that the percentages of costs and billed charges paid by Medicare patients and managed care patients should be the ceiling for workers' compensation reimbursement under the Labor Code.

[17] Pet. Ex. 32D at 5.

managed care programs to steer patients to hospitals, differences in the usual types of treatment (*e.g.* surgical v. non-surgical), and the typical inclusion of deductions and co-payments in managed care contracts.

Dr. Berry acknowledged that the Commission, in adopting the 1997 Guideline, had identified Medicare patients and commercial managed care patients as having equivalent standards of living to workers' compensation patients. Dr. Berry rejected that finding because it was made after the time period in question.

___, a health care consultant, testified concerning the percentage of hospital costs that were covered by the payments made under the 1992 Guideline.[18] ___used industry data to calculate the Texas average operating-cost-to-charge ratio for acute inpatient hospital services. He determined that the payments made pursuant to the Guideline covered only 62.5 percent of the hospitals' operating costs. He testified that percentage was far too low to allow for adequate care. He criticized Dr. Luke's use of variable costs, which excluded overhead items, because they did not reflect hospitals' actual costs and because their exclusion, in the real world, would preclude adequate medical care. Based on his analysis, ____testified that the percentage of cost reimbursement allowed by the 1992 Guideline was neither fair nor reasonable.

The Hospitals also presented testimony from _____, and___. All four are hospital administrators. Some of their testimonies concerned the individual test cases. Other portions, however, concerned the more general reimbursement issues. All four testified that hospital charge masters[19] are derived by individual institutions from many factors, including the cost of materials, the cost of providing services, pricing strategies, overhead, and others. In any event, however, charges must recover a hospital's costs plus a financial return. All four witnesses testified that hospitals operate in a competitive environment and cannot charge whatever they want.

_____ and ___also identified some differences between managed care and workers compensation, such as the existence of co-payments in managed care, the rights of hospitals to seek legal redress against managed care patients, and the concept of steerage, under which managed care

[18] ___testimony was admitted as Pet. Exs. 24 and 24A. The Hospitals also presented separate testimony from___. The references in this Decision to ___should be clear in context; if not, the Decision uses the witness' first name.

[19] A hospital's "charge master" is the master list of all charges for goods and services rendered at the hospital. Pet. Ex. 1 at 2.

insurers are able to direct patients to certain hospitals. According to the witnesses, that ability provides benefits to hospitals that justify discounts under managed care agreements. During the time period in question, steerage was not allowed under the workers compensation system, which in any event provides a much smaller percentage of hospital admissions than managed care.

_____ and ___also testified that although Medicare is cost-based, its reimbursement levels are insufficient to provide hospitals a financial return. Medicare, like managed care, provides a much higher percentage of hospital admissions than does workers' compensation. They observed that workers' compensation admissions also, in general, tend more toward trauma injuries and surgeries than illnesses.

The Carriers' primary witness on the issue of what level of reimbursement generally was fair and reasonable was Ron Luke, Ph.D.[20] Dr. Luke discussed the meaning of the statutory standards. He concluded that § 413.011 create upper and lower boundaries on a payment range, not a single "fair and reasonable" payment. In his opinion, the lower boundary was the level of reimbursement necessary to induce hospitals voluntarily to admit workers' compensation patients throughout the state. He opined that an economically rational hospital would admit such patients if it had excess capacity and could cover its variable costs of providing care. He testified that the hospitals had ample excess capacity from 1992 to 1997.

He further testified that during 1996-97, payments made under the 1992 Guideline covered 179 percent of the variable costs of the 70 hospitals in the Incipient Report, which contained the data set used by Hospital witness___.

Dr. Luke argued that the upper end of the range of "fair and reasonable" payments was the payments made for similar care for non-workers'compensation patients with equivalent standards of living. Dr. Luke expressed the opinion that Medicare and managed care patients have an equivalent standard of living to workers' compensation patients, a position accepted by the Commission when it adopted the 1997 Guideline. Using the Texas Department of Health's (TDH's) Annual Hospital Survey, which was compiled from data supplied by Texas hospitals, Dr. Luke compared the percent of billed charges Medicare and managed care paid each hospital and applied that to the amount of billed charges for workers' compensation patients. He determined Medicare paid approximately 45 percent and managed care paid approximately 44 percent of billed charges. He further determined

[20] Dr. Luke's testimony, errata, and report were admitted as Resp. Exs. 4, 4A, 4B, 5, and 6.

that those hospitals were reimbursed approximately 44 percent of billed charges under the 1992 Guideline.

Dr. Luke made a second managed care comparison, in which he relied upon the *per diem* managed care contracts that were supplied in discovery. He used only the *per diem* contracts because the Commission used those in developing the 1997 Guideline. Dr. Luke stated that the managed care reimbursement level under that approach was 31 percent of billed charges.[21]

Based on those comparisons, Dr. Luke testified that reimbursement of 85 to 100 percent of hospitals' billed charges, as requested by the Hospitals, was well above the upper limit set by the statute.

Dr. Luke stated he was using the percentage-of-billed-charges comparison only as a "common denominator" between the amounts paid under the Guideline, Medicare, and managed care, and the amounts requested by the Hospitals. In his opinion, using a percentage of billed charges to determine a fair and reasonable payment would not achieve effective medical cost control because hospitals determine how much they bill.

b. ALJ's analysis

The Hospitals' witnesses failed to prove that the level of reimbursement provided the Hospitals under the 1992 Guideline were unfair or unreasonable. The Hospitals also failed to show what level of reimbursement would be fair and reasonable under the statutory standards.

On cross-examination, Dr. Berry agreed he had not provided or attempted to provide any methodology for determining how much hospitals should be paid for workers' compensation services. He had not analyzed the effects of Medicare, managed care, or workers' compensation reimbursements on quality of medical care. He stated one could not quantify the value of managed care steerage and conceded he had not performed any studies on the ability of managed care programs to steer patients to participating hospitals. Although he has extensive experience in economics, Dr. Berry had never before worked in the area of workers' compensation, had not reviewed any managed care contracts and had not reviewed any data or studies on steerage of managed care patients. He also agreed that hospitals and managed care carriers had often entered into *per diem* contracts voluntarily for workers' compensation reimbursement and that such an

[21] Resp. Ex. 4 at 6-7 and Figure RPC-F.

agreement would be fair and reasonable for those parties.[22]

Dr. Berry did not perform a study to determine whether hospitals' costs exceeded the payments they had received under the 1992 Guideline. Neither did he perform any study of whether the managed care population had a standard of living equivalent to that of workers' compensation claimants. He contended that no population had an equivalent standard of living. He agreed that both income and net worth are relevant to standard of living. Yet, although he had compared the incomes of younger and older persons, he had not compared their net worths, which generally was higher for older persons.[23]

Although ___testified that the payments made by carriers were inadequate to cover hospitals' operating costs, he admitted he had not performed any calculations to determine what level of payment would be fair and reasonable.[24] Moreover, Dr. Luke and the Carriers successfully identified several substantial errors in ___calculations.[25] First, his cost estimates were overstated because he used an arithmetic average rather than a weighted average based on the number of workers' compensation admissions by hospital. ___contended the need for a general, rather than a hospital-specific, reimbursement level precluded the use of a weighted average. The ALJ finds that contention to be incorrect. Although the result is to be applied generally, the statute does not preclude the use of weighted hospital-specific data to calculate costs and revenues. __ asserted that the use of a weighted average would ignore higher cost incurred by smaller facilities. He offered no study to support that assertion. In any event, however, the ALJ agrees with Dr. Luke that an average that considers thenumber of admissions per hospital would be a more accurate reflection of the cost per patient. [26]

In making his calculations, ___also included small rural hospitals, specialty hospitals, and hospitals that had no inpatient workers' compensation admissions in fiscal year 1997. He agreed that those hospitals were excluded from the 1992 Guideline and that excluding them from his

[22] Tr. at 1088-99.

[23] Tr. at 1099-114.

[24] Tr. at 695-96.

[25] Respondent's Ex. 4 at 11-15.

[26] Tr. at 727; Pet. Ex. 24A at 3-4.

average could change the result significantly.[27]

Although he claimed he was using data from fiscal year 1997, ___actually used calendar year 1997 data. Dr. Luke pointed out that the use of calendar year 1997 data significantly overstated billed charges and included several months during which the 1997 Guideline was in effect. ____ did not contest those corrections and had not even checked Dr. Luke's computations.[28]

With regard to revenue, ___calculated the workers compensation payments received by hospitals in a very simple way: he multiplied (a) the actual number of workers' compensation admissions to each hospital by (b) that hospital's average length of stay for workers' compensation patients by (c) $1,100, which was the surgical *per diem* payment under the 1992 fee guideline. ___ described his use of the surgical *per diem* rate as a benchmark for estimating payments under the 1992 Guideline.

Dr. Luke observed that ___had access to data that showed the actual number of medical versus surgical admissions and the additional reimbursements for carve-outs and ICU/CCU days. Dr. Luke used that information to calculate a revenue estimate of $43.3 million, instead of the $28.8 million estimated by___, a difference of $15.5 million. Dr. Luke testified that ___estimate of how much carriers had paid was 36 percent less than shown by the available data. Dr. Luke stated that in the aggregate, carriers had paid $1,707 more than the per diem level for each surgical admission and $653 more than the per diem amount per medical admission.[29]

___did not check Dr. Luke's computations against the data available. He did not offer any information to refute Dr. Luke's assertion that those additional revenues had been paid.

He suggested that some of the additional revenue calculated by Dr. Luke could have been administrative penalties paid by carriers to hospitals. However, he had not investigated that

[27] Tr. At 727-29.

[28] Tr. at 733-37.

[29] Resp. Ex. 5 at 44-45.

possibility, which was purely conjecture on his part.[30]

Dr. Luke did not directly address the testimonies of_____, ____, and___. However, they did not make any general estimates of costs incurred or revenues received. Although they addressed problems with Medicare reimbursement, identified differences between Medicare and managed care injuries, and discussed the advantages provided by managed care steerage, they did not provide cost or revenue studies. They did not provide any testimony or data on whether Medicare, managed care, and workers' compensation patients have equivalent standards of living.

The Hospitals failed to provide any persuasive evidence that the amounts paid under the 1992 Guideline were unfair or unreasonable. Both Dr. Berry's and ____analyses were seriously flawed and unreliable. None of the Hospitals' witnesses clearly and methodically addressed the standards for determining reimbursement under TEX. LAB. CODE ANN. §413.001, which are at the heart of this case. In addition, the Hospitals' witnesses were overly concerned with how much workers' compensation patients would pay under free market economic principles. Dr. Berry, in particular, took issue with the standards set out in the statute. He and other Hospital witnesses emphasized the small volume of workers' compensation admissions versus Medicare and managed care and concluded that reimbursement for workers' compensation should be based on its market power, or lack thereof. Even if they wanted to, however, neither SOAH nor the Commission has the authority to abandon the statutory standards in favor of purely market-driven reimbursement for workers' compensation services.

The Hospitals' evidence would be inadequate to prove its case, even without any analysis by the Carriers of whether the level of payments made under the 1992 Guideline was fair and reasonable. Dr. Luke did analyze that issue in several ways, however.[31] The most persuasive were his comparisons of billed charges to the amounts paid under Medicare, managed care, and the 1992 Guideline. That is exactly the type of fee-for-service analysis required by the Court of Appeals in *All Saints*.

Dr. Luke based those analyses on the TDH Annual Survey data. The Hospitals questioned the reliability of that unaudited data. Although the data may not be perfect, it was provided by

[30] Tr. at 761-75; Pet. Ex. 12 at 4-6.

[31] The Hospitals did not cross-examine Dr. Luke. Tr. at 1194.

hospitals themselves, certified by each hospital to be correct, and reviewed by TDH for reasonableness and inconsistencies.[32] The Hospitals in this case never pointed to any specific errors or omissions and never offered any allegedly more reliable substitute data. The ALJ finds the TDH Annual Survey data to be reliable for the purpose of comparing Medicare and managed care billed charges to charges paid.

Dr. Luke's first analysis compared the percentage paid on charges billed for Medicare patients to the percentage paid on charges billed for workers' compensation patients under the 1992 Guideline. The percentages were virtually the same.

The ALJ finds Medicare patients had an equivalent standard of living to workers' compensation patients. He bases that finding on Dr. Luke's testimony and on the Commission's finding on that issue when it adopted the 1997 Guideline. Although *All Saints* prohibited the use of a *per diem* reimbursement scheme in deciding this case, it did not preclude the use of any Commission determinations. The Commission's declaration that Medicare patients had an equivalent standard of living to workers' compensation patients was made in 1997, not long after the services were provided in the test cases. Even for services provided longer ago, the ALJ finds it unlikely that the relative standards of living changed significantly for those two populations.

Dr. Luke's other analysis compared the percentage paid on charges billed for managed care patients to the percentage paid on charges billed for workers' compensation patients under the 1992 Guideline. The managed care data was not just for *per diem* contracts, but for all managed care agreements. The percentages were the same.

The ALJ finds managed care patients had an equivalent standard of living to workers' compensation patients. No witness other than Dr. Berry, who offered no analysis, disputed that contention. Although the Hospitals made much of the steerage available under managed care[33] and of the negotiated panoply of charges and services, none of that changes either those two populations' relative standards of living or the ratio of billed charges to the charges paid.

The ratio of billed charges to charges paid under the 1992 Guideline was equal (or almost

[32] Resp. Ex. 5 at 47.

[33] On cross-examination, the Carriers showed that many hospital managed care contracts from the time did not have exclusivity provisions.

equal) to the ratios for those two populations, each of which had equivalent standards of living to workers' compensation patients. Although Hospitals' witnesses contended Medicare reimbursement is too low, albeit without presenting data on the subject, no one contended hospitals were unable to provide adequate care to the Medicare population. And no one questioned the adequacy of either reimbursement or care for the managed care populations. The ALJ finds the managed care comparison to be the slightly more useful of the two, because the Hospitals agreed managed care payments generally recovered hospitals' costs and provided a profit.[34] Both of those analyses, however, showed affirmatively that the level of reimbursement provided under the 1992 Guideline was fair and reasonable within the meaning of TEX. LAB. CODE ANN. § 413.011.

Because the percentage-of-billed-charges comparisons provide adequate evidence that payments under the 1992 Guideline were fair and reasonable, the ALJ does not address at length Dr. Luke's variable cost analysis or his analysis of the actual *per diem* managed care contracts provided. In passing, however, the ALJ agrees with the Hospitals that one of those ways was seriously flawed. Dr. Luke erred in comparing only *per diem* managed care contracts, instead of the entire body of managed care contracts, to hospitals' billed charges. Dr. Luke limited himself to the *per diem* contracts because the Commission used only those in adopting its 1997 Guideline. However, the *All Saints* Court clearly rejected the *per diem* approach to determining fair and reasonable reimbursement levels in this case.[35]

The Hospitals argued that Dr. Luke's results were predetermined and that he was unqualified to testify about hospital costs and reimbursement. If Dr. Luke's data or results were inaccurate, however, the Hospitals had the opportunity to supply alternative data and studies. They also had the opportunity to object to Dr. Luke's testimony on the basis of his alleged lack of expertise, but did not do so. The ALJ finds those Hospital arguments to be unconvincing.

Even if the Hospitals had met their burden of proving that the level of reimbursement under the 1992 Guideline was inadequate, which they did not, the Hospitals had an additional responsibility to show what alternative level would be fair and reasonable under the statute. They did not do so. The Hospital witnesses asserted the charge masters were fair and reasonable and based on competition among health care providers. Even if true, however, those facts alone do not

[34] Tr. at 96-99.

[35] Although not every contract was admitted, the evidence shows plainly that managed care contracts from the period varied greatly in their reimbursement levels and terms and that many contracts provided for a discount from billed charges.

address all the standards for establishing a fair and reasonable level of reimbursement under TEX. LAB. CODE ANN. § 413.011. The Hospitals contended the percentages of billed charges that were reimbursed before the 1992 Guideline were fair and reasonable, but they provided no cost-based studies to support that contention. ___ did not attempt such a study and neither did Dr. Berry or the other witnesses. The Hospital witnesses appeared to believe that the practices in place before the 1992 Guideline established a default reimbursement level, if reimbursement under the 1992 Guideline were found inadequate. If that was their belief, they were mistaken. In *All Saints*, the Court indisputably ruled that the practices in place before the 1992 Guideline did not control the outcome of this case.

To summarize: The Hospitals failed to meet their burden of proving the levels of reimbursement provided under the 1992 Guideline were inadequate under the standards set out in TEX. LAB. CODE ANN. § 413.011. Using a fee-for-service analysis, the Carriers affirmatively proved the levels of reimbursement provided under the 1992 Guideline were fair and reasonable under those standards. Even if the Hospitals had shown those levels to be inadequate, they did not meet their burden of proving what alternative levels would be fair and reasonable.

The ALJ concludes the Hospitals are not entitled to any additional reimbursement if they were reimbursed the amounts required by the 1992 Guideline, unless a contract between the hospitals and the carriers specified a higher level of reimbursement. The contractual issue is discussed below.

2. Other common fairness and reasonableness issues

a. Contractually-based reimbursement

In two of the test cases, the Hospitals claim a contract was in place between the Hospital and the Carrier that required a higher level of reimbursement than was made. The Carriers argued that issue is outside the scope of this proceeding. The ALJ disagrees. The purpose of these cases is to determine the fair and reasonable payments levels due to the Hospitals. Using a percentage-of-billed-charges approach, the ALJ has determined the level of reimbursement set under the 1992 Guideline was fair and reasonable under TEX. LAB. CODE ANN. §413.011. The managed care and other contracts presented in this case show, however, that parties may reach a different agreement on what is fair and reasonable for the services provided by a particular hospital payable by a particular carrier. That amount takes into account different levels of reimbursement for different

services, along with many other factors.

The Commission recognized the relevance of contracts between the parties in deciding these cases, although it found the contractual information to be insufficient.[36] The ALJ concludes the issue of whether a contractual agreement required additional payment is before SOAH in these test cases and the other pending cases. SOAH has the authority to order additional payment based on contractual agreements.

b. Reimbursement for implantables

The other major issue is whether the Hospitals actually were reimbursed at the fair and reasonable levels set by the 1992 Guideline. Specifically, the Hospitals requested additional reimbursement for implantables, which are the hardware that may be implanted in a patient during orthopedic surgery, most notably spinal fusion surgery. Under the 1992 Guideline, implantables were to have been reimbursed separately, in addition to the *per diem* payments, at cost plus ten percent.

Nicholas Tsourmas, M.D., testified for the Carriers on the subject of the proper level of reimbursement for implantables. Dr. Tsourmas, who partly owns a surgical hospital, testified hospitals have very little overhead on those items. In his opinion, cost plus ten percent is, and was during the time in question, a fair and reasonable reimbursement level for implantables.[37] The Hospitals challenged that opinion, but did not offer any alternative analysis other than the testimonies of_____, and ____that their charge masters were reasonably based on costs, competition,and other factors. On cross-examination, ____agreed with Dr. Tsourmas that hospitals then and now keep very little inventory of implantables because it is cheaper and more efficient to allow surgeons to order specific hardware as needed.[38] Dr. Tsourmas' testimony on this issue was convincing. The ALJ finds cost plus ten percent was a fair and reasonable reimbursement level for implantables.

3. Test cases

[36] *See, e.g.*, Medical Review Division Findings and Decision, Docket No. 453-00-1677.M4HD, pp. 6-7.

[37] Resp. Ex. 43.

[38] Tr. at 82-83.

a. *Sierra Medical Center v. Continental Casualty Co.*, Docket No. 453-99-0355.M4HD

Date of Injury: ____

Dates of Service: December 18-19, 1996

Amount Billed to Carrier: $ 6,266.92

Amount Paid by Carrier: $ 1,100.00

Amount in Dispute: $ 5,166.92, plus interest if applicable

The service provided the patient in this case was an iliac crest bone graft for fusion of the metatarsal joints[39]on his left foot. The patient was in the hospital overnight. The Carrier, Continental Casualty Co. (Continental) paid $1,100, which was the surgical *per diem* under the 1992 Guideline. It did not reimburse Sierra Medical Center (Sierra) for the screws implanted in the patient in the fusion.

____, the Director of Payer Compliance and Litigation for the Tenet Health System Texas Region, testified on behalf of Sierra, which is owned by Tenet. ____testified Continental was a party to a health care services contract between Private Healthcare Systems, Inc. (PHCS) and Sierra, which obligated it to pay 65 percent of billed charges. Because Continental had not done so, Sierra was seeking 100 percent of billed charges.[40]

___ based his belief that Continental was a party to the PHCS/Sierra contract on Exhibit C to that contract, which lists Continental as a carrier. However, ___, an Assistant Vice President of Continental, stated in an affidavit that USA Workers Injury Network (USAWIN) was the PPO network used by Continental for workers compensation claims on both the date of service and the date the bill was audited. ___stated Continental previously had used PHCS, but had stopped doing so either before or at the time the USA WIN contract became effective on February 13, 1995. Sierra was not in the USA WIN PPO network and therefore received no discount. ___was personally involved in and had knowledge of vendor contracts during the time period in question.[41]

On cross-examination, ___ stated he had no reason to believe Continental was not a participating Payer under the PCHS contract.[42] He did not directly address ___affidavit, however, in

[39] Pet. Ex. 17 at 4 and Exhibit A (operative report).

[40] Pet. Ex. 17 at 5 and Exhibit C.

[41] Resp. Ex. 8. ___ Affidavit was admitted into evidence without objection.

[42] Tr. at 432.

either his live or written rebuttal testimony. The ALJ finds ___ testimony to be more credible because she had personal and specific knowledge of Continental's contractual situation at the time. The ALJ finds Continental was not a party to the PCHS contract at the time the service in this case was provided.

The billing and medical records included with ___ testimony show that implantables were billed at $430.40. Continental did not reimburse Sierra for those implantables. The 1992 Guideline required hospitals to submit copies of a recent invoice, if not necessarily the invoice for the actual hardware used, in order to be reimbursed. It is not clear from the record whether invoices were submitted to Continental as part of the reimbursement request in this case. ___ was unable to find the invoices in preparing for this case. As the Hospitals pointed out, however, the 1992 Guideline, and therefore the requirement to submit invoices, were no longer in place when the services were performed. Therefore, Sierra would be entitled to reimbursement for those implantables at cost plus ten percent.

In this case, however, Sierra did not provide any cost information.[43] Without such information, the ALJ is unable to determine a fair and reasonable reimbursement amount for the implantables. Therefore, he concludes Sierra did not meet its burden of proof on that issue and orders no additional reimbursement.

b. *East Houston Medical Center v. Texas Workers' Compensation Insurance Fund,* Docket No. 453-99-0643.M4HD

Date of Injury:	____
Dates of Service:	April 10-18, 1997
Amount Billed to Carrier:	$49,340.24
Amount Paid by Carrier:	$ 8,800.00
Amount in Dispute:	$40,540.24, plus interest if applicable

The patient in this case underwent follow-up spinal surgery after an earlier fusion, which included the placement of implantables. The Carrier, the Texas Workers' Compensation Insurance Fund (TWCIF), reimbursed East Houston Medical Center (EHMC) $8,800 for the eight-day stay, which was the surgical *per diem* under the 1992 Guideline.[44] TWCIF did not reimburse EHMC for

[43] ___ testified generally that Tenet's costs were probably 60-65 percent of its charges. Tr. at 414. He did not provide any testimony regarding Tenet's or Sierra's costs or mark-up on implantables, however.

[44] TWCIF initially reimbursed EHMC only $4,400, but was ordered to reimburse the additional $4,400 by the Commission's Medical Review Division. TWCIF did not request a hearing on that decision and has paid the additional $4,400.

the implantables. The parties agreed there was no contract between them regarding workers' compensation reimbursement.

EHMC billed $15,304.00 for the implantables.[45] As in the test case previously discussed, however, the record contains no cost information. Without such information, the ALJ is unable to determine a fair and reasonable reimbursement amount for the implantables. Therefore, he concludes EHMC did not meet its burden of proof on that issue and orders no additional reimbursement.

Dr. Tsourmas testified that the bulk of the surgery was medically unnecessary. According to Dr. Tsourmas, the only service that might have been necessary was removal of an EBI battery and electrodes, which might have required a two-day hospital stay. EHMC argues TWCIF waived that issue. The ALJ considers that issue to be moot, however, because there is no cost information to support additional reimbursement, and therefore has not addressed it.

c. *Southwest Texas Methodist Hospital v. Liberty Mutual Ins. Co.*, Docket No. 453-99-1677.M4HD

Date of Injury:	_____
Dates of Service:	September 3-13, 1996
Amount Billed to Carrier:	$22,319.93[46]
Amount Paid by Carrier:	$11,000.00
Amount in Dispute:	$11,319.93, plus interest if applicable

The service provided the patient in this case was a scheduled single-level L5-S1 spinal fusion, with disc removal and implantables installed. Liberty Mutual Insurance Company (LMIC) paid for ten days at the surgical per diem of $1,100 set out in the 1992 Guideline. LMIC did not reimburse the Hospital for the implantables.

Methodist Hospital (Methodist),[47] which is located in San Antonio, contends these services are covered by a contract between Methodist and Affordable Health Care Concepts (Affordable). LMIC admittedly was a member of the Affordable network.

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[45] Pet. Ex. 33 (___ testimony) at 5 and at pages 16, 22-23 of medical records.

[46] The total bill was $22,340.78, of which $20.85 was for non-covered services owed by the patient.

[47] Southwest Texas Methodist Hospital is now know as "Methodist Hospital."

The amended contract between Methodist and Affordable, in effect at the time of the services, set out the following acute inpatient services rate schedule to be in effect for admissions on or after January 1993:

> 5% discount from current Texas Workers' Compensation fee schedule
>
> 17% discount from billed charges*
>
> *to be in effect if the current Texas Workers' compensation fee schedule, effective September 1, 1992, is no longer in effect.

Methodist argues LMIC should have paid it 83% of its billed charges. Because LMIC failed to do so, however, Methodist argues LMIC owes it the full-billed charges, plus interest and attorneys' fees.

LMIC contends it owes neither 100 percent nor 83 percent of the billed charges. The contracts between Methodist and Affordable, on the one hand, and Affordable and LMIC, on the other, were separate documents. LMIC's contract with Affordable stated:

> COMPANY shall pay for compensable services at the rates specified in the Provider Agreements between AFFORDABLE and the Contract Providers, provided that in no event shall COMPANY be responsible to make payment at rates in excess of the lower of contract rates or fees mandated under applicable state law . . . .[48]

LMIC argues that the fees mandated under state law were the reimbursement levels set out in the 1992 Guideline, which the ALJ has found to be fair and reasonable. The ALJ agrees. Regardless of what Methodist and Affordable agreed to, LMIC agreed to pay only the fair and reasonable reimbursement required by TEX. LAB. CODE ANN. § 413.011. LMIC should not be required to reimburse Methodist 83 percent of its billed charges, because there was no agreement between the parties that reimbursement level was fair and reasonable.

Nor, obviously, should LMIC be required to reimburse Methodist 100 percent of its billed charges. Even if the Affordable contract applied, it contains no such provision for non-payment of disputed bills.

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[48] Although this contract was submitted under seal, that portion was quoted at the hearing and is not confidential. Tr. at 602.

Methodist argued that LMIC received benefits from the Affordable contract and equitably should be required to pay the rate set out in it. The ALJ concludes otherwise. First, LMIC did not agree to pay those rates. Second, although LMIC indisputably received benefits, as LMIC witness ___ agreed, the value of those benefits is not entirely clear. If the 1992 Guideline had been upheld in court, Methodist itself would have been willing to accept reimbursement at a 5 percent discount from that Guideline, which is less than LMIC provided and which Methodist argued was less than its costs. Moreover, only a few days after the discharge date in this case, Methodist and Affordable amended their agreement, establishing a *per diem* rate below the rate set out in the 1992 Guideline.[49]

The billing and medical records included with ___testimony show that implantables were billed at $5,735.00. Although Methodist's financial transactions log states the invoices were provided to LMIC, the copies of the invoices are not in the Hospital's records and LMIC contends it never received them. Again, it is not clear from the record whether invoices were submitted to LMIC as part of the reimbursement request in this case. However, as was discussed above, the 1992 Guideline, and therefore that requirement, was no longer in place when the services were performed. Although it would have been wise for Methodist to have submitted the invoices, it was not required to do so. The ALJ finds Methodist should be reimbursed for those implantables, at cost plus ten percent.

The cost of the implantables in this case was $3,835.[50] That cost, plus ten percent, equals $4,218.50. LMIC should reimburse Methodist an additional $4,218.50 for those implantables.

4. Interest

The Hospitals contend they are entitled to prejudgment interest on any additional reimbursement due. Payment of interest on workers' compensation fees is governed by TEX. LAB. CODE ANN.§ 413.019(a). That section states:

[49] Resp. Ex. 1 and 1A at 3. LMIC also argued that the 1992 Guideline remained in effect on the patient's September 3, 1996, admission date because of the Commission's pending appeal and its practice of enforcing the 1992 Guideline. The ALJ has not relied on that argument, which is moot for the reasons described in the body of this Decision.

[50] Resp. Ex. 43; Tr. at 83-84.

> Interest on an unpaid fee or charge that is consistent with the fee guidelines accrues at the rate provided by Section 401.023 beginning on the 60th day after the date the health care provider submits the bill to an insurance carrier until the date the bill is paid.
>
> (Emphasis added.)

One of the axioms of this case, expressly stated by the Court of Appeals in *All Saints*, is that no fee guideline was in place from September 1, 1992, to August 1, 1997, the period during which the services in these cases were provided. The Commission's rule at 28 TEX. ADMIN. CODE § 134.1, which adopted the "fair and reasonable" standard of the Labor Code, acknowledges it covered "reimbursement for services not identified in an established fee guideline." The Hospitals' own brief, while arguing for the payment of interest, acknowledges the 1992 Guideline was "court voided and invalid."[51] The ALJ concludes, as argued by the Carriers, that TEX. LAB. CODE ANN. §413.019(a) does not apply to these cases because the 1992 Guideline was void and no fee guideline was in place. Therefore, neither the Commission nor SOAH has statutory authority to award interest on unpaid reimbursement.

The Hospitals further argue that, if prejudgment interest is not authorized by statute, "the court can award interest under general principles of equity," citing *Johnson & Higgins of Texas v. Kenneco Energy, Inc.*, 962 S.W.2d 507, 528 (Tex. 1998). SOAH and the Commission are not courts, however; they are administrative agencies. State agencies' powers are limited to those expressly granted by statute or necessarily implied to implement that authority.[52] In *Concord Oil Co. v. Pennzoil Explo. & Prod. Co.*, 966 S.W.2d 451, 462-63 (Tex. 1998), the Texas Supreme Court discussed *Johnson & Higgins* and restated that prejudgment interest is available before the Workers' Compensation Commission only to the extent authorized by statute. Neither SOAH nor the Commission can award prejudgment interest on equitable principles.

Even if SOAH or the Commission could award prejudgment interest on equitable principles, it is not certain that equity favors the Hospitals. Although these cases have dragged on for a very long time, it is possible they would have been resolved much sooner if the Hospitals had sought only contractually based reimbursement and reimbursement for implantables.

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[51] Hospitals' initial brief at 59.

[52] *Pub. Util. Comm'n v. City Pub. Serv. Bd.*, 53 S.W.3d 310, 315-16 (Tex. 2001).

5. Attorneys' fees

In their brief, the Hospitals request attorneys' fees. Neither SOAH nor the Commission has legal authority to award attorneys' fees in workers' compensation reimbursement disputes.

6. Effect of this Decision and Order

This Decision and Order is a final decision in the three test cases. The findings and conclusions on the general level of fair and reasonable reimbursement under TEX. LAB. CODE ANN. §413.001, the fairness and reasonableness of contractually-based reimbursements, the fair and reasonable reimbursement level for implantables, and SOAH's and the Commission's lack of authority to award interest and attorneys' fees apply to all the 1992 Guideline cases pending at SOAH. Docket No. 453-99-0533.M4HD will remain open to facilitate the processing of those cases. The ALJ will issue a proposed procedural order in those remaining cases, soliciting the parties' input, in the near future.

IV. FINDINGS OF FACT

Procedural history

1. In 1989, the Texas Legislature made significant changes to the Texas Workers' Compensation Act (the Act). Under the revised Act, the Texas Workers' Compensation Commission (the Commission) was required to establish fee guidelines.

2. On December 21, 1990, the Commission adopted an emergency fee guideline, which took effect January 1, 1991, and expired June 30, 1991 (the 1991 Emergency Guideline). Under that guideline, carriers were to reimburse hospitals based on a fixed percentage of each hospital's stated charges for services.

3. No guideline was in place from June 30, 1991, until September 1, 1992, when the 1992 Acute Care Hospital Fee Guideline (the 1992 Guideline) took effect. The 1992 Guideline took a very different approach to reimbursement, dividing medical services into categories, *e.g.* surgical and intensive care, and setting a *per diem* reimbursement rate for each category.

4. Several hospitals challenged the 1992 Guideline in court. In December of 1995, the Third Court of Appeals invalidated the 1992 Guideline, declaring it void and unenforceable for lack of an adequate reasoned justification. The Commission appealed that decision to the Texas Supreme Court, which denied the writ on February 13, 1997.

5. Effective August 1, 1997, the Commission adopted another fee guideline (the 1997 Guideline), which also used the *per diem* method of reimbursement, although it differed from its predecessor in some respects.

6. Although the 1992 Guideline had been declared void, many carriers continued reimbursing hospitals until August 1, 1997, at the levels set in that Guideline. The Commission did not require a different level of reimbursement.

7. Because of the ongoing lawsuit and the Court of Appeals' decision mentioned in Finding of Fact No. 4, many of the hospitals did not file requests for dispute resolution seeking additional payments within the one-year deadline set in the Commission's rule at 28 TEX. ADMIN. CODE (TAC) § 133.305(a).

8. On February 24, 1997, the Commission's Executive Director issued a memorandum stating the Commission would not consider requests for dispute resolution pertaining to the 1992 Guideline that had not been timely filed under the one-year rule. The Texas Hospital Association and certain hospitals sued the Commission regarding that policy.

9. In July of 1997, those parties entered into a Compromise Settlement Agreement (the CSA). Under the CSA, the Commission agreed it would accept and process requests for dispute resolution from hospitals until August 15, 1998, for services provided between September 1, 1992, and February 14, 1997, if the requests for reimbursement were based on the statutory criteria set out in TEX. LAB. CODE ANN. § 413.011(b) and on the fact that the 1992 Guideline had been declared invalid by the courts.

10. Hospitals filed more than 20,000 claims at the Commission requesting reimbursement on the basis that payments made under the 1992 Guideline were not fair and reasonable.

11. After the CSA deadline passed, the Commission began issuing decisions in the individual cases before it. In each instance in which a decision was issued, the Commission found the hospital had failed to provide sufficient documentation to support additional reimbursement.

12. The hospitals filed timely requests for hearing in those cases, which then were referred to the State Office of Administrative Hearings (SOAH).

13. At SOAH, a joint prehearing conference was held on March 19, 1999, in thirteen of the hospital requests. The threshold procedural and legal issues in those cases, and eventually other cases involving the 1992 Guideline, were consolidated into Docket No. 453-99-0533.M4HD, *Re: Hospital Fee Guideline Disputes*. The parties to that case were numerous Petitioner hospitals (the Hospitals) and Respondent workers' compensation carriers (the Carriers).

14. After issuing Order No. 6, which decided several threshold legal issues, and considering suggestions from the parties, the ALJ established a procedure under which several of the individual cases would be designated as "test cases" to proceed to hearing.

15. Order No. 10, issued in September of 2000, designated five test cases. The Hospitals filed written direct testimony and exhibits and the cases were referred, unsuccessfully, to mediation.

16. In February of 2002, after an order resolving pending discovery disputes, the Hospitals moved for abatement of the SOAH proceedings. Although the ALJ originally denied the motion, he abated this proceeding on August 21, 2002, after the district court ruled in the Carriers' favor on the issue of the applicability of the Commission's one-year rule to these cases.

17. The Third Court of Appeals, in *Hospitals v. Continental Cas. Co.*, 109 S.W.3d 96 (Tex. App.-Austin 2003, pet. denied), precluded hospitals from pursuing the many claims that had been filed more than one year after the date of the disputed services. After their appeals of the decision had been exhausted, the Hospitals undertook the task of determining which of

the pending SOAH cases had been filed more than one year after the disputed service dates, and provided that information to the ALJ.

18. In Joint Orders Nos. 19 and 22, the ALJ dismissed more than 150 of the hospital cases referred to in Finding of Fact No. 12, including four of the five test cases.

19. In Joint Order No. 21, the ALJ designated four new test cases to join the one remaining original test case. Two of those eventually were dismissed-one due to settlement and one because the Hospital could no longer find the applicable records leaving the three test cases that are partly the subject of this decision.

20. After the filing of additional testimony, discovery, and a further continuance, the hearing in these cases was convened June 12, 2006. The hearing was adjourned June 21, 2006. The parties' initial written closing arguments were filed on August 25, 2006, and reply arguments on September 25, 2006, when the record was closed.

General fair and reasonable reimbursement levels

21. Hospitals' witness George Berry, Ph.D., did not provide or attempt to provide any methodology for determining how much hospitals should be paid for workers' compensation services.

22. Dr. Berry did not analyze the effects of Medicare, managed care, or workers' compensation reimbursements on quality of medical care.

23. Dr. Berry had never before worked in the area of workers' compensation, did not review any managed care contracts, and did not review any data or studies on steerage of managed care patients.

24. Dr. Berry did not perform a study to determine whether hospitals' costs exceeded the payments they had received under the 1992 Guideline.

25. Dr. Berry did not perform any study of whether the managed care population had a standard of living equivalent to that of workers' compensation claimants.

26. Although both income and net worth are relevant to standard of living, Dr. Berry did not compare the net worths of younger and older persons in comparing the standards of living of workers' compensation patients and Medicare patients.

27. Hospitals' witness ___did not perform any calculations to determine what level of payment would be fair and reasonable for the services at issue in these cases.

28. ___cost estimates were overstated because he used an arithmetic average rather than a weighted average based on the number of workers' compensation admissions by hospital.

29. In making his calculations, ___incorrectly included small rural hospitals, specialty hospitals, and hospitals that had no inpatient workers' compensation admissions in fiscal year 1997.

30. Although he claimed he was using data from fiscal year 1997, ___actually used calendar year 1997 data.

31. ___use of calendar year 1997 data significantly overstated billed charges and included

several months during which the 1997 Guideline was in effect.

32. With regard to revenue, ___calculated the workers' compensation payments received by the hospitals in a very simple way: he multiplied (a) the actual number of workers' compensation admissions to each hospital by (b) that hospital's average length of stay for workers' compensation patients by (c) $1,100, which was the surgical *per diem* payment under the 1992 fee guideline.

33. The parties had access to data that showed the actual number of medical versus surgical admissions and the additional reimbursements for carve-outs and ICU/CCU days.

34. ___estimate of how much the carriers had paid for workers' compensation admissions was 36 percent less than shown by the available data.

35. In the aggregate, carriers paid $1,707 more than the per diem level for each surgical admission and $653 more than the per diem amount per medical admission.

36. The additional revenue discussed in Finding of Fact No. 35 was not attributable to administrative penalties paid by carriers to hospitals.

37. Both Dr. Berry's and ___analyses were seriously flawed and unreliable.

38. The Hospitals' witnesses were overly concerned with how much workers]' compensation patients would pay under free market economic principles.

39. The Hospitals failed to provide any persuasive evidence that the amounts carriers paid under the 1992 Guideline were unfair or unreasonable.

40. Carriers' witness Ron Luke, Ph.D., compared billed charges to the amounts actually paid under Medicare, managed care, and the 1992 Guideline.

41. Dr. Luke used Texas Department of Health (TDH) Annual Survey data in his percentage-of-billed-charges comparisons.

42. The TDH Annual Survey data was provided by hospitals themselves, certified by each hospital to be correct, and reviewed by TDH for reasonableness and inconsistencies.

43. The TDH Annual Survey data is reliable for the purpose of comparing Medicare and managed care billed charges to charges actually paid.

44. The percentage of billed charges paid for Medicare patients was virtually the same as the percentage of billed charges paid for workers' compensation patients under the 1992 Guideline.

45. Medicare patients had an equivalent standard of living to workers' compensation patients.

46. The percentage of billed charges paid for managed care patients was the same as the percentage of billed charges paid for workers' compensation patients under the 1992 Guideline.

47. The managed care data was not just for *per diem* contracts, but for all managed care

agreements.

48. Managed care patients had an equivalent standard of living to workers' compensation patients.

49. Hospitals provided adequate care to the Medicare population.

50. Hospitals provided adequate care to the managed care population.

51. The reimbursement provided hospitals for managed care was adequate.

52. Even if the level of reimbursement under the 1992 Guideline had been inadequate, which it was not, the Hospitals did not show what alternative level would be fair and reasonable.

Other common fairness and reasonableness issues

53. "Implantables" are the hardware that may be implanted in a patient during orthopedic surgery, most notably spinal fusion surgery.

54. Under the 1992 Guideline, implantables were to have been reimbursed separately, in addition to the *per diem* payments, at cost plus ten percent.

55. Hospitals have very little overhead on implantables.

56. As is the case now, hospitals kept very little inventory of implantables because it is cheaper and more efficient to allow surgeons to order specific hardware as needed.

57. Cost plus ten percent is a fair and reasonable reimbursement level for implantables.

Test cases

***Sierra Medical Center v. Continental Casualty Co.*, Docket No. 453-99-0355.M4HD**

58. Some of the basic facts in *Sierra Medical Center v. Continental Casualty Co.*, Docket No. 453-99-0355.M4HD, are set out below:

Date of Injury:	____
Dates of Service:	December 18-19, 1996
Amount Billed to Carrier:	$ 6,266.92
Amount Paid by Carrier:	$ 1,100.00
Amount in Dispute:	$ 5,166.92, plus interest if applicable

59. The service provided the patient in the *Sierra* case was an iliac crest bone graft for fusion of the metatarsal joints on his left foot. The patient was in the hospital overnight.

60. The Carrier, Continental Casualty Co. (Continental), paid $1,100, which was the surgical *per diem* under the 1992 Guideline. It did not reimburse Sierra Medical Center (Sierra) for the screws implanted in the patient in the fusion.

61. USA Workers Injury Network (USAWIN) was the PPO network used by Continental for workers compensation claims on both the date of service and the date the bill was audited.

62. Continental previously had used Private Healthcare Systems, Inc. (PHCS) as a PPO, but had stopped doing so either before or at the time the USA WIN contract became effective on February 13, 1995.

63. Continental was not a party to the PCHS contract at the time the services in this case were provided.

64. Sierra is not entitled to reimbursement from Continental at 65 percent of billed charges, as provided in the PHCS contract.

65. Implantables were billed at $430.40.

66. Sierra did not provide any cost information for the implantables.

67. Without cost information, one cannot determine a fair and reasonable reimbursement amount for the implantables in the *Sierra* case.

***East Houston Medical Center v. Texas Workers' Compensation Insurance Fund*, Docket No. 453-99-0643.M4HD**

68. Some of the basic facts in *East Houston Medical Center v. Texas Workers' Compensation Insurance Fund*, Docket No. 453-99-0643.M4HD, are set out below:

Date of Injury:	_____
Dates of Service:	April 10-18, 1997
Amount Billed to Carrier:	$49,340.24
Amount Paid by Carrier:	$ 8,800.00
Amount in Dispute:	$40,540.24, plus interest if applicable

69. The patient in this case underwent follow-up spinal surgery that included the placement of implantables.

70. The Carrier, the Texas Workers' Compensation Insurance Fund (TWCIF), reimbursed East Houston Medical Center (EHMC) $8,800 for the eight-day stay, the surgical *per diem* set out in the 1992 Guideline. TWCIF did not reimburse EHMC for the implantables.

71. There was no contract between the parties regarding workers' compensation reimbursement.

72. EHMC billed $15,304.00 for the implantables.

73. EHMC did not provide any cost information for the implantables.

74. Without cost information, one cannot determine a fair and reasonable reimbursement amount for the implantables in the EHMC case.

***Southwest Texas Methodist Hospital v. Liberty Mutual Ins. Co.*, Docket No. 453-99-1677.M4HD**

75. Some of the basic facts in *Southwest Texas Methodist Hospital v. Liberty Mutual Ins. Co.*, Docket No. 453-99-1677.M4HD, are set out below:

Date of Injury: _____

Dates of Service:	September 3-13, 1996
Amount Billed to Carrier:	$22, 319.93
Amount Paid by Carrier:	$11,000.00
Amount in Dispute:	$11,319.93, plus interest if applicable

76. The service provided the patient in this case was a scheduled single-level L5-S1 spinal fusion, with disc removal and implantables installed.

77. The Carrier, Liberty Mutual Insurance Company (LMIC) paid for ten days at the surgical per diem of $1,100 set out in the 1992 Guideline. LMIC did not reimburse the Hospital for the implantables.

78. LMIC was a member of the Affordable Health Care Concepts (Affordable) network at the time the services were provided.

79. The amended contract between Methodist Hospital (Methodist) and Affordable, in effect at the time of the services, set out the following acute inpatient services rate schedule for beneficiaries of occupational ill/injured workers' compensation payers, to be in effect for admissions on or after January 1993:

> 5% discount from current Texas Workers' Compensation fee schedule
> 17% discount from billed charges*
> *to be in effect if the current Texas Workers' compensation fee schedule, effective September 1, 1992, is no longer in effect.

80. The contracts between Methodist and Affordable, on the one hand, and Affordable and LMIC, on the other, were separate documents.

81. LMIC's contract with Affordable stated:

> COMPANY shall pay for compensable services at the rates specified in the Provider Agreements between AFFORDABLE and the Contract Providers, provided that in no event shall COMPANY be responsible to make payment at rates in excess of the lower of contract rates or fees mandated under applicable state law . . . .

82. The fees mandated under state law were the reimbursement levels set out in the 1992 Guideline, which were fair and reasonable.

83. Regardless of what Methodist and Affordable agreed to, LMIC agreed to pay only the fair and reasonable reimbursement required by TEX. LAB. CODE ANN. § 413.011.

84. There was no agreement between LMIC and Methodist that 83 percent of billed charges was fair and reasonable.

85. Methodist billed $5,735.00 for the implantables.

86. The cost of the implantables was $3,835.

87. The cost of the implantables, plus ten percent, equals $4,218.50.

88. The fair and reasonable amount of reimbursement for the implantables is $4,218.50.

V. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(Vernon 1996) and TEX. GOV'T CODE ANN. ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

3. The Court of Appeals' decision in *Texas Hospital Ass'n v. Texas Workers' Compensation Commission*, 911 S.W.2d 884 (Tex. App. - Austin 1995, writ denied) (*THA v. TWCC*) has retroactive application in the sense that it applies to all claims submitted and paid under the Commission's 1992 Acute Care Inpatient Hospital Fee Guideline (the 1992 Guideline).

4. The standard that governs claims submitted and paid under the 1992 Guideline is TEX. LAB. CODE ANN. § 413.011 (Vernon 1996), not the Commission's previous Guideline or the parties' practices before the 1992 Guideline took effect. *All Saints Health Sys. v. Texas Workers' Comp. Comm'n*, 125 S.W.3d 96 (Tex. App.-Austin 2003, pet. denied).

5. The stop/loss provision of the 1992 Guideline does not apply to the pending claims.

6. The claims under the 1992 Guideline are not barred by the doctrine of res judicata.

7. Commission Rule 133.305 (28 TEX. ADMIN. CODE § 133.305) required the dismissal of disputes based solely on the 1992 Guideline that were not filed with TWCC within one year of the date the hospital services were provided. *Hospitals v. Continental Cas. Co.*, 109 S.W.3d 96 (Tex. App.-Austin 2003, pet. denied).

8. The burden of proof in these cases is on the party appealing the Commission's decision. In every case relating to claims submitted and paid under the1992 Guideline, that party is the Hospitals.

9. The Court's rejection of a *per diem* reimbursement scheme in *All Saints* was not *dicta*. It was part of the Court's holding in the case.

10. Under *All Saints*, all managed care contracts may be considered as relevant evidence in determining what reimbursement level is fair and reasonable under the Labor Code.

11. The Court in *All Saints* did not rule that the amounts paid by carriers were unfairly or unreasonably low merely because they were calculated on a *per diem* basis.

12. Under *All Saints*, a percentage-of-billed charges approach must be used in determining what level of reimbursement is fair and reasonable under TEX. LAB. CODE ANN. § 413.011(d).

13. The level of reimbursement provided under the 1992 Guideline was fair and reasonable within the meaning of TEX. LAB. CODE ANN. § 413.011.

14. Hospitals are not entitled to any additional reimbursement if they were reimbursed at the

level of reimbursement provided under the 1992 Guideline, unless a contract between the hospitals and the carriers specified a higher level of reimbursement.

15. Parties may reach a different agreement on what is fair and reasonable for the services provided by a particular hospital payable by a particular carrier.

16. The issue of whether a contractual agreement required additional payment is before SOAH in these test cases and the other pending cases.

17. SOAH has the authority to order additional payment based on contractual agreements between the parties.

18. In *Sierra Medical Center v. Continental Casualty Co.*, Docket No. 453-99-0355.M4HD, Continental provided fair and reasonable reimbursement to Sierra within the meaning of TEX. LAB. CODE ANN.§ 413.011.

19. Continental should not be required to provide additional reimbursement to Sierra for the services provided.

20. In *East Houston Medical Center v. Texas Workers' Compensation Insurance Fund*, Docket No. 453-99-0643.M4HD, TWCIF provided fair and reasonable reimbursement to EHMC within the meaning of TEX. LAB. CODE ANN. § 413.011.

21. TWCIF should not be required to provide additional reimbursement to EHMC for the services provided.

22. In *Southwest Texas Methodist Hospital v. Liberty Mutual Ins. Co.*, Docket No. 453-99-1677.M4HD, LMIC provided fair and reasonable reimbursement to Methodist within the meaning of TEX. LAB. CODE ANN. § 413.011, except that LMIC should reimburse Methodist for implantables at cost plus ten percent.

23. LMIC should reimburse Methodist an additional $4,218.50 for the implantables.

24. LMIC should not be required to provide additional reimbursement to Methodist for the other services provided.

25. Payment of interest on workers' compensation fees is governed by TEX. LAB. CODE ANN. § 413.019(a).

26. TEX. LAB. CODE ANN.§ 413.019(a) does not apply to these cases because the 1992 Guideline was void and no fee guideline was in place.

27. Neither the Commission nor SOAH has statutory authority to award prejudgment interest on unpaid reimbursement for claims submitted and paid under the 1992 Guideline.

28. State agencies' powers are limited to those expressly granted by statute or necessarily implied to implement that authority.

29. Neither SOAH nor the Commission can award prejudgment interest on equitable principles.

30. Neither SOAH nor the Commission can award prejudgment interest on unpaid

reimbursement for claims submitted and paid under the 1992 Guideline.

31. Neither SOAH nor the Commission can award attorneys' fees in workers' compensation reimbursement cases.

ORDER

IT IS, THEREFORE, ORDERED:

A. For all cases pending at SOAH under the 1992 Acute Care Hospital Fee Guideline (the 1992 Guideline):

1. Reimbursement at the levels set in the 1992 Guideline is fair and reasonable within the meaning of TEX. LAB. CODE ANN. § 413.011, unless the parties contractually agreed to a higher level of reimbursement for services provided workers' compensation patients. In the absence of a contractual agreement, Carriers shall not be required to provide additional compensation beyond the levels set in the 1992 Guideline

2. Reimbursement at contractually-agreed levels is fair and reasonable within the meaning of TEX. LAB. CODE ANN. § 413.011 for the contracting parties. Carriers may be ordered to provide additional reimbursement at contractually-agreed levels.

3. Implantables shall be reimbursed at cost plus ten percent.

4. Carriers are not required to pay prejudgment interest on additional reimbursements ordered.

5. Parties are not required to pay attorneys' fees.

B. For the three test cases:

1. In *Sierra Medical Center v. Continental Casualty Co.*, Docket No. 453-99-0355.M4HD, Continental Casualty Co. is not required to pay additional reimbursement to Sierra Medical Center for the services provided.

2. In *East Houston Medical Center v. Texas Workers' Compensation Insurance Fund*, Docket No. 453-99-0643.M4HD, the Texas Workers' Compensation Insurance Fund is not required to pay additional reimbursement to East Houston Medical Center for the services provided.

3. In *Southwest Texas Methodist Hospital v. Liberty Mutual Ins. Co.*, Docket No. 453-99-1677.M4HD, Liberty Mutual Ins. Co. (LMIC) shall reimburse Methodist Hospital (Methodist) an additional $4,218.50 for implantables. LMIC is not required to pay additional reimbursement to Methodist for other services provided.

SIGNED November 20, 2006.

HENRY D. CARD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS