SOAH DOCKET NO. 454-12-5238.M4
DWC NO. _____

SEABRIGHT INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
SIERRA MEDICAL CENTER,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Seabright Insurance Company (Seabright) seeks to deny additional reimbursement to Sierra Medical Center (Sierra) for inpatient hospital surgical services provided to an injured worker (Claimant) from June 3, 2011, to June 5, 2011, at Sierra. The Administrative Law Judge (ALJ) finds Sierra is entitled to additional reimbursement in the amount of $7,014.81.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no issues of notice or jurisdiction. Therefore, these matters are addressed in the Findings of Fact and Conclusions of Law without further discussion.

Sierra filed a request for medical fee dispute resolution with the Medical Review Division (MRD) of the Texas Department of Insurance, Division of Workers' Compensation (Division). On March 7, 2012, the Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision) ordering additional reimbursement of $7,014.81. Seabright timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest MRD's determination.

A hearing convened before ALJ Steven M. Rivas on July 25, 2012, at SOAH's facilities in Austin, Texas. Seabright was represented by attorney Steven M. Tipton. Sierra was represented by attorney Matthew O'Neil. The record first closed on August 20, 2012, following the filing of post-hearing briefs. The record closed again on October 16, 2012, after the ALJ reopened the record in

order to allow the parties an opportunity to provide the ALJ with a copy of the diagnostic related group (DRG) codes at issue in this matter.

II. DISCUSSION

A. Applicable Law

This case is governed by the Tex. Lab. Code (Labor Code) § 401.001*et seq.*, also known as the Texas Workers' Compensation Act (Act). The workers' compensation insurance program created by the Act covers all medically necessary health care.[1] A party, including a health care provider is entitled to review of a medical service provided if a health care provider is denied payment for the medical service rendered.[2]

Section 413.011 of the Act directs the Division's Commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements. To achieve standardization, the commissioner shall adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services (CMS), including applicable payment policies relating to coding, billing, and reporting.[3]

The Division's inpatient hospital fee guideline found at 28 Tex. Admin. Code § 134.404, *et seq.* is the applicable reimbursement methodology for the services in question. For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is

[1] Tex. Lab. Code § 401.011.

[2] Tex. Lab. Code § 413.031(a)(1) and 28 Tex. Admin Code § 133.307.

[3] Tex. Lab. Code § 413.011(a).

provided.[4] Under the applicable fee guideline, the maximum allowable reimbursement shall be the Medicare facility-specific amount, including outlier payment amounts, multiplied by 143 percent.[5]

B. Evidence

1. Background Facts

Claimant sustained a work-related compensable back injury on ____, and underwent a preauthorized lumbar laminectomy at Sierra on June 2011. Claimant remained at Sierra following the surgery until June 2011, when he was released. Sierra billed Seabright $15,503.07 for the services rendered at Sierra.

In billing for its services, Sierra utilized the DRG codes.[6] A provider may use DRG code 490[7] when a patient who undergoes a lumbar laminectomy also has what is known as a comorbid condition such as high blood pressure, hypertension, diabetes, or a body mass index (BMI) of 40 or over indicating obesity. If a patient does not have a comorbid condition, a provider shall use DRG code 491[8] when calculating its billing for inpatient services resulting from a lumbar laminectomy procedure. The parties generally agree that a patient with a comorbid condition is more susceptible to complications that may arise from a surgical procedure even though actual complications need not be shown, and that using DRG code 490 is an "upcode" that results in a higher reimbursable amount than if a provider uses DRG code 491.

The parties also agreed that the maximum allowable reimbursement for the services rendered should equal 143% of the Medicare allowable amount. Using DRG code 490, Sierra calculated the Medicare allowable amount to be $10,841.31 for the services rendered. Conversely, Seabright, by using DRG code 491, calculated the Medicare allowable amount to be $5,935.85. After multiplying

[4] 28 TAC 134.404(d).

[5] *Id.* at (f)(1)(A).

[6] Carrier provided a copy of the applicable DRG codes to the ALJ on October 16, 2012.

[7] SURG BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM

[8] SURG BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC

each amount by 143%, Sierra concluded it was entitled to reimbursement of $15,503.07, while Seabright calculated Sierra's reimbursement to be $8,488.26. Seabright paid this amount to Sierra on August 1, 2011, leaving $7,014.81 in dispute.

2. Sierra

Miguel Fuentes, Sierra's code supervisor, testified that the DRG codes were established by CMS, and that Sierra uses these codes in determining the appropriate billing amount for inpatient services. In this case, it was determined that Claimant had a BMI of 45, according to an admission document.[9] As such, Mr. Fuentes asserted, Claimant had a comorbid condition by having a BMI of over 40, and the inpatient surgical services were correctly coded using DRG code 490.

3. Seabright

Seabright did not present any witness testimony[10] but argued that while Sierra may have been entitled to use DRG code 490, it was not mandatory that Sierra use this code. According to Seabright, nothing compelled Sierra to use DRG code 490 and that if it had used DRG code 491, it would have suffered no consequence other than being reimbursed a lesser amount. In other words, Seabright contends, both methods are correct and neither is incorrect under CMS guidelines.

Additionally, Seabright argued that under the Labor Code it has authority and discretion to pay a claim based on a case-by-case analysis of the facts of the hospital admission. Seabright argued that absent any evidence that Sierra encountered actual complications or increased costs, it should not be required to reimburse Sierra under DRG code 490 for the services it provided to Claimant. Seabright also argued that, because it is a Texas workers' compensation carrier, it has additional requirements to uphold that CMS does not—namely the bill review provisions of the Labor Code, specifically § 413.011(d).

[9] Sierra Exhibit No. 1 at page SMC0168. See also the anesthesia report at SMC0130 and operative report at SMC0128, which refer to Claimant as having "morbid obesity" and being "extremely obese," weighing over 350 lbs.

[10] At the time of the hearing, the ALJ twice attempted to contact Seabright's witness___, by telephone, to no avail.

Seabright argues that under § 413.011(d), a carrier is authorized to choose the lowest cost alternative between otherwise acceptable payments. Seabright also argues that, pursuant to the Labor Code's umbrella requirement of utilizing cost-effective healthcare, it may choose any amount under its chosen methodology—in this case $8,488.26 as if Sierra had used DRG code 491 in its billing.

C. Analysis and Conclusion

The sole issue is whether Sierra's bill was correctly coded for purposes of establishing the correct reimbursement. Seabright argues that although Sierra was entitled to use DRG code 490, it could have, in its discretion, used DRG code 491 when it coded and billed this claim. However, Seabright offered no plausible explanation or reason as to why Sierra should choose not to utilize DRG code 490 under the circumstances presented.

The ALJ is not persuaded by Seabright's argument that using either code would be correct. The correct DRG code is the one that more accurately corresponds with a claimant's condition. In light of Claimant's clear comorbid status, it follows that billing under DRG code 490 is correct and, for these reasons, the ALJ finds Sierra correctly coded the laminectomy.

Moreover, the methodology in place for calculating reimbursement at 143% of the Medicare rate is undisputed. Although the Labor Code emphasizes that injured workers are to be treated by cost-effective means, the evidence reflects the claim was coded correctly and meets all regulatory and industry standards for a patient with a comorbid condition.

The ALJ is also not persuaded by Seabright's argument that it may reimburse Sierra a lesser amount under DRG code 491 if Sierra provides no evidence that Claimant suffered actual complications or if Sierra presented no evidence that it took precautionary measures in performing the surgery. There are no qualifying terms within the language of DRG code 490 that require a provider to show it encountered actual complications or that it took precautionary measures in providing back surgery, and Carrier failed to show that more is required of a provider when billing under DRG Code 490. Without such language and without other proof that complications must be present or that precautionary measures must actually be taken, the ALJ finds Seabright failed to meet

its burden and should pay $7,014.81 in additional reimbursement to Sierra for the services provided to Claimant.

III. FINDINGS OF FACT

1. On June 2011, a workers' compensation claimant underwent a lumbar laminectomy at Sierra Medical Center (Sierra) and remained at Sierra until he was released on June 2011.

2. Seabright Insurance Company (Seabright) was the responsible workers' compensation insurer for the claimant.

3. Sierra billed Seabright $15,503.07 for the services it rendered to the claimant.

4. Seabright reimbursed Sierra $8,488.26.

5. Sierra requested additional reimbursement, which Seabright denied.

6. Sierra timely filed a request for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division).

7. On March 7, 2012, the Division's Medical Review Division (MRD) issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision), finding that $7,014.81 in additional reimbursement was owed to Sierra.

8. Seabright timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the MRD Decision.

9. A Notice of Hearing informed the parties of the date, time, and location of the hearing; the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

10. A hearing convened before Administrative Law Judge Steven M. Rivas on July 25, 2012, at SOAH's facilities in Austin, Texas. Seabright was represented by attorney Steven M. Tipton. Sierra was represented by attorney P. Matthew O'Neil. The record first closed on August 20, 2012, following the filing of closing briefs. The record closed again on October 16, 2012, to allow the parties an opportunity to submit additional evidence to the ALJ.

11. Sierra utilized diagnostic related group (DRG) codes in billing Seabright for the services rendered to Claimant at Sierra.

12. Claimant had a body mass index (BMI) of 45 at the time the services were rendered.

13. A claimant with a BMI of over 40 is considered to have a comorbid condition.

14. DRG code 490 is the correct code to utilize when processing a reimbursement claim for a lumbar laminectomy procedure that is performed on a claimant with a comorbid condition.

15. Sierra correctly utilized DRG code 490 in processing its reimbursement claim for the services rendered to the claimant.

IV. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to Tex. Lab. Code § 413.031 and Tex. Gov't Code ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Tex. Gov't Code §§ 2001.051 and 2001.052.

3. The services provided to Claimant were covered by a fee guideline issued by the Division within the meaning of Tex. Lab. Code § 413.011.

4. Sierra correctly processed its reimbursement under the Division's applicable rules at 28 Tex. Admin. Code § 134.404.

5. Sierra is entitled to additional reimbursement from Seabright for the services provided to Claimant.

ORDER

IT IS ORDERED that Seabright pay additional reimbursement in the amount of $7,014.81 to Sierra for the services provided to Claimant.

SIGNED November 9, 2012.

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS