SOAH DOCKET NO. 454-14-1561.M4-NP
DWC MR NO. _____

ST. DAVID'S REHABILITATION OAKS HOSPITAL, **Petitioner**	§	**BEFORE THE STATE OFFICE**
	§	
	§	
	§	**OF**
v.	§	
	§	
TRAVELERS INDEMNITY CO., **Respondent**	§	
	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

St. David's Rehabilitation Oaks Hospital (Provider) requested a hearing to contest a medical fee dispute resolution order issued by the Texas Department of Insurance, Division of Workers' Compensation (Division) regarding a claim for $52,490.00 in medical services provided to ___ (Claimant). In its order, the Division found that Provider was not entitled to reimbursement from Travelers Indemnity Co. (Carrier) in addition to the amount already paid by the Carrier. After considering the evidence and the arguments presented, the Administrative Law Judge (ALJ) finds that Provider is entitled to an additional reimbursement of $14,785.44, plus any applicable interest.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

There are no contested issues of notice or venue in this proceeding. These matters are addressed in the findings of fact and conclusions of law without further discussion.

The hearing on the merits convened on March 14, 2014, before ALJ Roy G. Scudday at the State Office of Administrative Hearings (SOAH), Austin, Texas. Provider was represented by Attorney James G. Gumbert. Carrier was represented by Attorney William E. Weldon. The record closed upon the conclusion of the hearing.

II. DISCUSSION

A. Background

From ___ through ___, Claimant, an employee of ____ received inpatient rehabilitation services from Provider, an inpatient rehabilitation facility (IRF), for the treatment of injuries sustained while on the job. On May 22, 2012, Provider provided a claim for those services in the amount of $52,490.00 to Carrier.[1] On June 19, 2012, Carrier issued an explanation of benefits (EOB) for the claim approving an amount of $10,157.58. The EOB stated that the services were rendered in a non-Texas, non-Inpatient Prospective Payment System (IPPS) acute care facility and were "re-priced in accordance to the contractual agreement between carrier and provider" and in accordance with the Diagnostic Related Group (DRG) Rate.[2] (An additional payment of $5,797.93 was paid after the issuance of the fee dispute resolution order, leaving a balance of reimbursement sought by Provider of $36,534.49.)

Provider's original claim indicated a service code of DRG945. Provider submitted a corrected claim reflecting a service code of Case Mixed Group (CMG) A1703.[3] On August 14, 2012, Carrier issued an EOB stating that the claim had been properly processed the first time and additional reimbursement was not justified.[4]

A Medical Fee Disposition Resolution Decision (MRD Decision) issued October 24, 2013, found that Provider had failed to support its position that additional reimbursement was due.[5]

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[1] Provider Ex. 1 at 3-17.

[2] *Id.* at 19-21.

[3] *Id.* at 22.

[4] *Id.* at 23-24.

[5] Carrier Ex. 1 at 19-21.

B. Evidence

1. MRD

The MRD Decision set forth certain statements of the Division in regard to reimbursements based on hospital charges as follows:

> The Division has previously found, as stated in the adoption preamble to the former *Acute Care Impatient Hospital Fee Guideline,* that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269).
>
> . . .
>
> The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the former *Acute Care Impatient Hospital Fee Guideline,* which states at 22 *Texas Register* 6276 that:
>
> > A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, which would be administratively burdensome for the Commission and system participants, and would require additional Commission resources. [6]

2. Testimony of Jana Lee

Ms. Lee is the Payment Compliance Director at Parallon Business Performance Group, which provides business and operational services for Hospital Corporation of America (HCA), the owner of

[6] *Id.* at 20-21.

Provider. In that capacity, Ms. Lee is responsible for overseeing the daily operations of the Underpayment Discrepancy Department, in which capacity she reviewed this fee dispute.

Ms. Lee testified that, because there was no applicable fee guideline for the services provided, and because there was no negotiated contract with the Carrier (no such contract was submitted into evidence despite the statement on the EOB that such a contract existed), the fair and reasonable reimbursement for the services provided was the billed amount of $52,490.00. Her opinion was based on the following:

- The services provided were for multiple rehabilitation training or therapy for major multiple trauma without brain or spinal injury with CMG Code A1703 rather than DRG Code 945, which latter code is only appropriate for acute care hospitals, not inpatient rehabilitation facilities.
- The Provider's cost for the services provided, based on the Medicare calculation of costs, was $17,759.24, more than the total amount reimbursed by Carrier.
- The billed charges would help ensure the quality of medical care while still achieving effective medical cost control.
- The billed charges would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The billed charges would be based upon and consistent with available reimbursement values for services involving similar work and resource commitments.

Ms. Lee testified regarding two alternate methods for determining a fair and reasonable reimbursement amount. One method would be to adopt the approach applied by the Division to non-IRF health facilities by taking the average conversion/payment adjustment factors applied to Ambulatory Surgical Care (ASC) facilities (235%), Outpatient (OP) facilities (200%) and Acute Care Inpatient (ACIP) facilities (143%) as a multiplier applied to the Medicare rate for the services provided. She testified that using this method would result in a fair and reasonable reimbursement meeting the statutory criteria in an amount still owed of $14,785.44.[7]

[7] Provider Ex. 2 at 9.

The second alternate method suggested by Ms. Lee was to use the Provider's average reimbursement percentages for certain categories of payers for CMG Code A1703. For all IRF Health Maintenance Organization accounts from 2011-2013, the average percentage would be 60%, or an amount still owed of $15,533.09. For all IRF accounts from 2012, and all CMG A1730 Medicare accounts for 2011-2013, the average percentage would be 43%, or an amount still owed of $6,611.32. For all IRF accounts for 2011-2013 and all managed Workers Compensation accounts from 2011-2013, the average percentage would be 41%, or an amount still owed of $5,561.70.[8]

C. Applicable Law

Texas Labor Code (Code) § 413.011sets forth reimbursement policies and guidelines and includes the following:

> (e) The commissioner by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols. Treatment guidelines and protocols must be evidence-based, scientifically valid, and outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines.
> (f) In addition to complying with the requirements of Subsection (e), medical policies or guidelines adopted by the commissioner must be:
> (1) designed to ensure the quality of medical care and to achieve effective medical cost control;
> (2) designed to enhance a timely and appropriate return to work; and
> (3) consistent with Sections 413.013, 413.020, 413.052, and 413.053.

The Division Rule that seeks to effect the above-referenced reimbursement guidelines is located at 28 Texas Administrative Code (TAC) § 134.1, which includes the following:

> (e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:
> (1) the Division's fee guidelines;
> (2) a negotiated contract; or

[8] Provider Ex. 2, p. 12.

(3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

(f) Fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code § 413.011;

(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

D. Analysis

As noted in the MRD Decision, the Division has stated that reimbursement methodologies that use billed hospital charges as their basis or that use a percentage of hospital billed charges as their basis do not provide acceptable fair and reasonable reimbursement amounts. In accordance with this stated policy, neither the billed hospital charges nor an amount based on a percentage of billed hospital charges can be considered to be a fair and reasonable reimbursement amount. However, the methodology used by the Division itself of taking the average conversion/payment adjustment factors applied to ASC facilities, OP facilities, and ACIP facilities as a multiplier applied to the Medicare rate for the services provided would result in a fair and reasonable amount. As a result, the ALJ finds that Provider is entitled to an additional reimbursement of $14,785.44, plus any applicable interest.

III. FINDINGS OF FACT

1. ___ (Claimant) suffered a compensable injury on ____.

2. On the date of injury, Travelers Indemnity Co. (Carrier) was the workers' compensation insurance carrier for Claimant's employer.

3. Claimant received inpatient rehabilitation services from St. David's Rehabilitation Oaks Hospital (Provider), an inpatient rehabilitation facility (IRF), for the treatment of his injuries.

4. On May 22, 2012, Provider provided a claim for those services in the amount of $52,490.00 to Carrier.

5. On June 19, 2012, Carrier issued an explanation of benefits (EOB) for the claim approving an amount of $10,157.58. The EOB stated that the services were rendered in a non-Texas,

non-Inpatient Prospective Payment System acute care facility and were "re-priced in accordance to the contractual agreement between carrier and provider" and in accordance with the Diagnostic Related Group (DRG) Rate.

6. Provider's original claim indicated a service code of DRG945. Provider submitted a corrected claim reflecting a service code of Case Mixed Group (CMG) A1703.

7. On August 14, 2012, Carrier issued an EOB stating that the claim had been properly processed the first time and additional reimbursement was not justified.

8. On October 24, 2013, a Medical Fee Disposition Resolution Decision (MRD Decision) was issued by the Texas Department of Insurance, Division of Workers' Compensation (Division), finding that Provider had failed to support its position that additional reimbursement was due.

9. An additional payment of $5,797.93 was paid to Provider by Carrier after the issuance of the MRD.

10. On November 8, 2013, Provider requested a hearing by the State Office of Administrative Hearings (SOAH) to contest the MRD Decision.

11. The Division referred the matter to SOAH on December 31, 2013.

12. On January 23, 2014, the Division issued a Notice of Administrative Hearing to Carrier and Provider.

13. The notice of hearing set forth the nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

14. On March 14, 2014, SOAH Administrative Law Judge (ALJ) Roy G. Scudday held a contested case hearing concerning the dispute at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. At the hearing, Provider appeared through its attorney, James G. Gumbert, and Carrier appeared through its attorney, William E. Weldon. The record closed at the conclusion of the hearing.

15. The Division has stated that reimbursement methodologies that use billed hospital charges as their basis or that use a percentage of hospital billed charges as their basis do not provide acceptable fair and reasonable reimbursement amounts.

16. The Division has determined that a methodology to determine a fair and reasonable amount of reimbursement for services provided by non-IRF health facilities is by using the average conversion/payment adjustment factors applied to Ambulatory Surgical Care facilities (235%), Outpatient facilities (200%) and Acute Care Inpatient facilities as a multiplier applied to the Medicare rate for the services provided.

17. The reimbursement amount sought for the services provided in this case using the methodology described in Finding of Fact No. 16 is $14,785.44, plus any applicable interest.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order. Tex. Lab. Code §§ 402.073(b), 413.031, 413.0311, and 413.055; and Tex. Gov't Code ch. 2003.

2. Notice of the hearing was proper and timely. Tex. Gov't Code §§ 2001.051-.052.

3. Provider had the burden of proving by the preponderance of the evidence that it was entitled to additional reimbursement for services provided. 1 Tex. Admin. Code § 155.427.

4. Based upon the facts set forth in Findings of Fact Nos. 16 and 17, Carrier is liable to Provider for an additional payment of $14,785.44, plus any applicable interest.

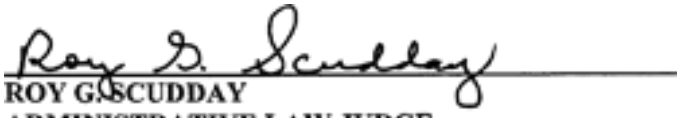
ORDER

THEREFORE, IT IS ORDERED THAT Travelers Indemnity Co. is required to pay the sum of $14,785.44, plus any applicable interest, to St. David's Rehabilitation Oaks Hospital in additional reimbursement for the services at issue in this case.

NONPREVAILING PARTY DETERMINATION

Texas Labor Code § 413.0312(g) and 28 Texas Administrative Code § 133.307(h) require the nonprevailing party to reimburse Division for the cost of services provided by SOAH. Texas Labor Code § 413.0312(i) requires SOAH to identify the nonprevailing party and any costs for services provided by SOAH in its final decision. For purposes of Texas Labor Code § 413.0312, Travelers Indemnity Co. is the nonprevailing party. The costs associated with this decision are set forth in Attachment A to this Decision and Order and are incorporated herein for all purposes.

SIGNED March 28, 2014.



ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS