SOAH DOCKET NO. 454-15-1876.M4-NP

ZURICH AMERICAN INSURANCE CO.,	§	**BEFORE THE STATE OFFICE**
	§	
Petitioner	§	
	§	**OF**
v.	§	
	§	
TEXAS HEALTH FORT WORTH,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

Zurich American Insurance Co. (Carrier) appeals the approval of full reimbursement to Texas Health Fort Worth (Provider) for services provided to an injured worker because the Provider released the injured worker to a rehabilitation facility rather than home. The Administrative Law Judge (ALJ) concludes that under the Inpatient Hospital Fee Guideline (Guideline), the Provider was not entitled to additional reimbursement and is entitled to only $30,914.83.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

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

On May 22, 2014, Provider filed a request for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division). On November 6, 2014, the Division issued its Medical Fee Dispute Resolution Findings and Decision finding that Provider was entitled to additional reimbursement of $10,762.60. On December 31, 2015, Carrier requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination. On January 9, 2015, the Division issued a Notice of Hearing. A hearing convened before ALJ Steven D. Arnold on May 4, 2015, at SOAH's facilities in Austin, Texas. Provider was represented by Workers' Compensation Claims Auditor Karen Lynch. Carrier was represented by its attorney, James Loughlin. Carrier

filed it brief on May 22, 2015, the Division filed an *amicus curiae* brief that same day, and Provider filed a brief on June 1, 2015, at which point the record closed.

II. APPLICABLE LAW

The Texas Labor Code provision relating to reimbursement policies and guidelines states:

> The commissioner shall 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, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet the requirements of Section 413.053.[1]

III. EVIDENCE AND ANALYSIS

Agreed Facts

The facts of this case are not in dispute. The parties agreed that the Claimant was admitted to Provider's facility on September 5, 2013. The Claimant was discharged five days later on September 10, 2013, to Pate Rehabilitation (a Commission on Accreditation of Rehabilitation Facilities accredited post-acute residential treatment program).

Carrier contends that the release of the Claimant to the rehabilitation facility triggers application of the Medicare transfer policy and results in a lower level of reimbursement ($30,914.83).

Provider contends that the Division has never differentiated reimbursement based on whether a claimant was released to home or a rehab facility and that the reimbursement should be $41,677.44 under the Guideline. Therefore, Provider seeks additional reimbursement of $10,762.60.

The Medical Fee Dispute Resolution sided with Provider and found that additional reimbursement of $10,762.60 was appropriate.

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[1] Tex. Labor Code § 413.011(a).

Parties' Positions on Applicable Law

Provider argued that since the inception of the new fee schedule in 2008 all of the Department's decisions on inpatient claims (with or without transfers at the time of discharge) have been at the higher rate unless the provider requested separate reimbursement. This is consistent with the Medical Fee Dispute resolution Findings and Decision, although the Provider alluded to many decisions that supported this position both at hearing and in its brief, none were specifically cited and the only references were anecdotal.

The Carrier argued that the Texas Workers' Compensation Act, the Guideline, and the preamble to the Guideline establish that the Guideline incorporates the Medicare Acute Care Hospital Inpatient Prospective Payment System (IPPS) Transfer Policy, which limits the amount payable to the Provider in this situation.

Carrier argued that the legislative intent, as expressed in the plain language of this statute, is to adopt the Medicare reimbursement methodologies with only minimal modifications, and only as necessary to meet occupational injury requirements, to achieve standardization. Carrier noted that the emphasis on minimal modifications is repeatedly employed in the 2002 preamble to Rule 134.202, which was the first medical fee guideline adopted pursuant to the legislative directive.[2] Carrier argued that modifications are to be specified in the text of the rule.[3] Carrier contends that this means that the Division does not have to reprint the Medicare policies in its own fee guidelines because it has adopted everything it has not specifically excluded.[4]

Carrier noted that the Division adopted the current Guideline effective March 1, 2008. The Guideline requires workers' compensation participants to apply Medicare payment policies in effect on the date of service with only those additions or exceptions specifically stated in a rule.[5] According to Carrier, modifications to Medicare payment policies cannot be implied or inferred; they must be specified by rule, and there is no exception for Medicare's transfer policy specified in the Guideline.

Finally, Carrier pointed to the Division's response to a commenter who proposed that the Division create an exception to the Medicare payment policies for the Medicare transfer policy when the Division adopted the Guideline:

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[2] *See*, 27 Tex. Reg. 4058-4059, 4066, 4091 (2002).

[3] 27 Tex. Reg. 4068 (2002).

[4] Carrier notes that, for example, the Division's medical fee guideline creates a specific exception to Medicare's payments policies for chiropractors so they can participate in the workers' compensation system citing to 28 Texas Administrative Code § 134.203(a)(6) ("Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.").

[5] 28 Tex. Admin. Code § 134.404(d).

> In regard to inpatient services, the commenter also recommends that the PAF be increased to account for the application of the Medicare transfer rules or that both hospitals be paid the full [Diagnosis Related Group (DRG)] amount.
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> …
>
> In regard to the comment concerning Medicare transfer rules, the Division notes that paying both facilities the full DRG in transfer situations would result in significant overpayment for a stay and is contrary to the effective medical cost control provisions of the Labor Code.[6]

The Division noted this provision in its brief, as well, and argued that if the Medicare transfer policy was applicable to the facts of the case, the Medicare transfer policy must be applied.

Analysis and Discussion

The Act provides that the Division must adopt guidelines that incorporate the Medicare transfer policy. As discussed in the preamble, the Guideline limits the amount payable to Provider in this situation. The Labor Code makes clear that Medicare's reimbursement policies are adopted and only limited exceptions are permitted. The Guideline (and, in particular, the preamble to the Guideline) make clear that the transfer policy is not excepted. Accordingly, the Provider is not entitled to additional reimbursement of $10.762.60, and is limited to reimbursement of $30,914.83.

IV. FINDINGS OF FACT

1. Claimant, an injured worker, suffered a compensable injury.

2. Claimant was admitted to Texas Health Fort Worth (Provider) on September 5, 2013. The principal procedure code listed was for brain meninge repair (other repair of cerebral meninges).

3. Claimant was discharged five days later on September 10, 2013, to Pate Rehabilitation (a Commission on Accreditation of Rehabilitation Facilities accredited post-acute residential treatment program).

4. If the Medicare transfer policy applies to Claimant's release, Zurich American Insurance Co. (Carrier) would be required to reimburse Provider $30,914.83. If the transfer policy does not apply, Carrier would be required to reimburse Provider an additional $10,762.60.

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[6] 33 Tex. Reg. 418 (2008).

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

6. On November 6, 2014, the Division issued its Medical Fee Dispute Resolution Findings and Decision finding that the Medicare transfer policy did not apply and finding that Carrier must reimburse Provider the additional $10,762.60.

7. Carrier timely requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination.

8. On January 9, 2015, the Division issued a Notice of Hearing. The notice 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.

9. The hearing was held May 4, 2015, before Administrative Law Judge Steven D. Arnold, at the SOAH offices located in Austin, Texas. Provider was represented by Workers' Compensation Claims Auditor Karen Lynch. Carrier was represented by its attorney, James Loughlin. Carrier filed it brief on May 22, 2015, the Division filed an amicus curiae brief that same day, and Provider filed a brief on June 1, 2015, at which point the record closed.

V. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to Texas Labor Code § 413.031 and Texas Government Code ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Texas Government Code §§ 2001.051 and 2001.052.

3. Carrier had the burden of proof in this proceeding.

4. The Medicare transfer policy applied to the release of the Claimant to a rehabilitation facility. Tex. Labor Code § 413.011(a); 28 Tex. Admin. Code 134.404(d).

5. Provider is entitled to reimbursement by Carrier of $30,914.83.

ORDER

THEREFORE, IT IS ORDERED THAT Zurich American Insurance Co. is required to pay the sum of $30,914.83 to Texas Health Fort Worth as compensation for the services at issue in this case.

NON-PREVAILING PARTY DETERMINATION

Texas Labor Code § 413.0312(g) and 28 Texas Administrative Code § 133.307(h) require the non-prevailing party to reimburse the Division for the cost of services provided by SOAH. Texas Labor Code § 413.0312(i) requires SOAH to identify the non-prevailing party and any costs for services provided by SOAH in its final decision. For purposes of Texas Labor Code § 413.0312, Texas Health Fort Worth is the non-prevailing 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.

ISSUED July 29, 2015.

Steven D. Arnold

STEVEN D. ARNOLD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS