

No. 03-07-00682-CV

IN THE
COURT OF APPEALS
FOR THE THIRD DISTRICT OF TEXAS AT AUSTIN

TEXAS MUTUAL INSURANCE COMPANY, *et al.*,
Appellants,

v.

VISTA COMMUNITY MEDICAL CENTER, LLP, *et al.*,
Appellees.

Appealed from the 353rd Judicial District Court
Of Travis County, Texas
Trial Court Cause No. D-1-GN-06-000213
Honorable Margaret Cooper, Presiding

BRIEF OF AMICUS CURIAE
INSURANCE COUNCIL OF TEXAS

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August 15, 2008

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TEXAS MUTUAL INSURANCE COMPANY, *et al.*,
Appellants,

v.

VISTA COMMUNITY MEDICAL CENTER, LLP, *et al.*,
Appellees.

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STATEMENT OF THE CASE

Nature of the case. This case involves the interpretation and validity of a subsection of the Texas Department of Insurance, Division of Worker's Compensation's (the "Division") Acute Care Inpatient Hospital Fee Guideline ("1997 Guideline") known as the "stop-loss" exception. Although the 1997 Guideline states that all inpatient services provided by an acute care hospital for medical and/or surgical admissions will be reimbursed using a standard per diem amount, the district court has held that the stop-loss exception provides that if the total audited charges on a hospital bill exceed \$40,000.00, then the hospital shall be reimbursed at seventy-five (75%) percent of that amount.

Course of proceedings. The Texas Worker's Compensation Commission, the predecessor agency to the Division, after this Court invalidated the Texas Worker's Compensation Commission's 1992 Hospital Fee Guideline in *Texas Hosp. Ass'n v. Texas Workers' Comp. Comm'n*, 911 S.W.2d 884, 886 (Tex. App. – Austin 1995, writ denied), adopted the 1997 Guideline. 22 Tex. Reg. 6264 (July 4, 1997). In February 2005, a Staff Report was issued by the agency interpreting the stop-loss exception subsection. The Staff Report stated that the "stop-loss" exception required a two prong test in order for "stop-loss" reimbursement.

Subsequently, the Division resolved a medical dispute pursuant to the Staff Report that was adverse to Vista Medical Center Hospital. Vista Medical Center Hospital appealed the adverse Division decision directly to the Travis County District Court in Cause No. D1-GN-06-000213; *Vista Medical Center Hospital v. Texas Mutual Insurance Company and the Division of Workers Compensation*. Vista Medical Center Hospital claimed the Staff

Report was an invalid agency rule. Texas Mutual Insurance Company counterclaimed contending among other things that the “stop-loss” exception” was a two prong test and if Vista Medical Center Hospital and other hospitals were correct in their interpretation, then the “stop-loss” exception subsection is invalid because it violates Texas Labor Code Section 413.011 and is an unconstitutional delegation. Zenith Insurance Company (among others) intervened seeking declaratory relief on the fact that the “stop-loss” exception subsection fails to conform to a legislative mandate that fee guidelines use Medicare based reimbursement methodologies and that the Division failed to review and revise the \$40,000.00 minimum stop-loss threshold, despite a legislative mandate to do so at least every two years.

Trial court disposition. Following a trial to the court, the Honorable Margaret Cooper, entered a Final Judgment on November 6, 2007, holding that: (1) the “stop-loss” exception subsection applies whenever a hospital’s audited charges exceed \$40,000.00; (2) the Division’s Staff Report interpreting the subsection to require that an admission must also involve unusually extensive services was an invalid agency rule; and (3) the “stop-loss” exception subsection, as interpreted by the court, is a valid rule. CR 1343.

ISSUE PRESENTED FOR REVIEW

The stop-loss exception to the Acute Care Inpatient Hospital Fee Guideline (28 Tex. Admin. Code §134.401(c)(6)) is invalid as construed by the District Court because the exception fails to provide for fair and reasonable reimbursement, conflicts with Texas Labor Code Section 413.011, is not Medicare based and was not reviewed every two years.

STATEMENT OF FACTS

Insurance Council of Texas is a Texas nonprofit corporation which functions as a trade association of property/casualty insurance carriers in Texas. Its membership includes nearly all of the major carriers transacting insurance business in Texas. The members that write workers compensation insurance in Texas provide the vast of majority of such coverage for Texas employers. Its members have a direct interest in the issues presented in this case and, for that reason join in the filing of this *Amicus Curiae* Brief to provide the insights of its members to assist this Honorable Court in its deliberations.

Insurance Council of Texas is the entity on whose behalf the Amicus Curiae Brief is tendered and Insurance Council of Texas is the source of the fee paid counsel, John D. Pringle, for preparing the Brief.

In August 1997, after this Court invalidated the Texas Workers' Compensation Commission's 1992 Hospital Fee Guideline in *Texas Hosp. Ass 'n v. Texas Workers' Comp. Comm 'n*, 911 S.W.2d 884, 886 (Tex. App. -- Austin 1995, writ denied), the Texas Workers' Compensation Commission (Commission)¹ adopted an Acute Care Inpatient Hospital Fee Guideline (1997 Guideline) by rule relating to payments to hospitals for services provided to workers' compensation patients. 22 Tex. Reg. 6264 (July 4, 1997), Joint Exhibit 1-2. In the 1997 Guideline, the Commission adopted the same per diem methodology for

¹ In 2005, the Texas Legislature abolished the Texas Workers' Compensation Commission and transferred its duties and rules to the Texas Department of Insurance, Division of Workers' Compensation. See Act of May 29, 2005, 79th Leg. R.S., ch. 265, §§ 8.001(b), 8.004(a), 2005 Tex. Gen. Laws 468, 607-11.

payments to hospitals as in the 1992 Hospital Fee Guideline, with slightly different payment amounts. In the order adopting the 1997 Guideline, the Commission clearly described the reasons that statewide per diems based on three large groups met the Texas Labor Code criteria.

The Commission soundly rejected the use of a percentage of billed charges methodology. 22 Tex. Reg. 6264, 6268-69 (July 4, 1997). Relying on statements by the hospitals themselves, the Commission found that hospitals' billed charges were "basically meaningless in the current managed care environment." 22 Tex. Reg. at 6303. They did not have "a consistent, and rational relationship to either payments accepted by hospitals for services or to hospital costs." 22 Tex. Reg. at 6292. In response to a comment, the Commission explained:

Each hospital determines its own charges. The hospital charge data in the Commission's database, as with all hospital charge data, shows that it is well above the actual fees paid for most hospital services. A study by Commission staff indicated that charges for surgical hospital admissions (per TWCC billing database) increased by 107% from 1992 to 1996 and by 65% from 1993 to 1996, whereas for the same periods of time the Consumer Price Index (CPI) reflected an inflation rate of 16% and 12% respectively, and the Medical Care Services group of the CPI reflected an inflation rate of 29% and 18% respectively. For these reasons, 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 Tex. Reg. at 6297.

A percentage of billed charges methodology was "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.” 22 Tex. Reg. at 6276.

The 1997 Guideline provided that hospitals will be paid one of three statewide per diem amounts: \$870 per day for general admissions; \$1,118 per day for surgical admissions; and \$1,560 per day for intensive care unit (ICU) and cardiac care unit (CCU) admissions. 28 TEX. ADMIN. CODE § 134.401(c)(1).

However, after stating in 28 TEX. ADMIN. CODE § 134.401(c)(2) that “[a]ll inpatient services provided by an acute care hospital for medical and/or surgical admissions will be reimbursed using a service related standard per diem amount,” the 1997 Guideline provides for payments in addition to per diems for some services. (Emphasis added). In particular, the 1997 Guideline provides that hospitals are entitled to reimbursement for implants at cost plus ten (10%) percent in addition to the per diem amount. *Id.* § 134.401(c)(4)(A)(i). Implants are devices, such as rods, screws, and cages that remain embedded in the patient’s tissues following surgery.

In addition, the 1997 Guideline also provides two exceptions to the required per diem payment methodology. First, the 1997 Guideline provides that payment for trauma, burns, and Human Immunodeficiency Virus cases will be at a “fair and reasonable rate.” *Id.* § 134.401(c)(5). Second, the 1997 Guideline provides for “stop-loss payment.” *Id.* §134.401(c)(6).

The 1997 Guideline describes the “stop-loss” exception to the standard per diem methodology as “an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment of an injured worker.” *Id.* § 134.401(c)(6). A hospital admission is “eligible” for “stop-loss” payment when the total audited charges for the admission exceed \$40,000.00, “the minimum ‘stop-loss’ threshold.” *Id.* § 134.401(c)(6)(A)(i). “This ‘stop-loss’ threshold is established to ensure compensation for unusually extensive services required during an admission.” *Id.* § 134.401(c)(6)(A)(ii). If audited charges exceed the stop-loss threshold, reimbursement for the entire admission is seventy-five (75%) percent of audited charges. *Id.* § 134.401(c)(6)(A)(iii), (iv).

“Audited charges” are defined as “those charges which remain after a bill review by the insurance carrier has been performed.”² *Id.* § 134.401(c)(6)(A)(v). The “stop-loss” exception itself allows deduction of charges for personal items. *Id.* Other general applicable Texas Workers’ Compensation Commission, now Texas Department of Insurance, Division of Workers’ Compensation³ audit rules allow the carrier to review bills

2. The term “bill review” was not defined by the Texas Workers’ Compensation Commission. The Texas Department of Insurance, Division of Workers’ Compensation defined the term “bill review” when it adopted 28 TEX. ADMIN. CODE § 133.2(1) to be effective May 2, 2006. 31 Tex. Reg. 3544 (April 28, 2006).

3. ICTI will try and refer to the Texas Workers’ Compensation Commission (“Commission”), in this Statement of Facts when any action was taken by the Commission and will try and refer to the Texas Department of Insurance, Division of Workers’ Compensation (“Division”), in this Statement of Facts when any action was taken by the Division.

for consistency with fee and treatment guidelines, duplicate billing, improper or inaccurate coding, incorrect calculations, and medical necessity among other things. 28 TEX. ADMIN. CODE § 133.301(a) (repealed effective May 2, 2006); 28 TEX. ADMIN. CODE § 133.230 (effective May 2, 2006).

I. The Dispute Over the “Stop-Loss” Exception

Understanding the history of the dispute about how to properly interpret and apply the “stop-loss” exception as it relates to the issues of (1) unusually extensive and costly admissions, and (2) implants, requires one to look at: (A) the Commission, including communications from lower level staff members, medical dispute resolution officers and high-level policy makers; (B) the State Office of Administrative Hearings (“SOAH”), decisions including two separate consolidated dockets which reached diametrically opposite decisions on threshold legal issues; (C) carriers like Texas Mutual Insurance Company which disputed inpatient admissions as not being “unusually extensive” since at least 2001, and (D) hospitals like Vista Medical Center Hospital, where implant costs were routinely charged to insurance carriers at four hundred (400%) of the cost to Vista Medical Center Hospital.

A. Early Staff Communications

Several staffers at the Commission took the position that implant charges should be audited to cost plus (10%) percent and paid at cost plus ten (10%) percent. In October 1997, Commission staffer Nancy Crawley instructed attendees at the Texas Medical Cost

Containment Association conference that implants should be reduced to cost plus ten (10%) percent when reviewing a hospital bill to determine if the bill met the minimum “stop-loss” threshold. Joint Exhibit 1-3-1 at p. 8. In October 1999, Vangie Stice, Section Chief for the Commission Medical Review Division (“MRD”), responded to an inquiry regarding whether the \$40,000.00 minimum “stop-loss” threshold is met based on the the invoice price of the implants (cost to the hospital) or the charged price of the implants (to the insurance carrier). Ms. Stice stated: “According to the Acute Care Inpatient Hospital Fee Guideline, (c)(4)(A), the maximum allowable reimbursement (MAR) for implantables is cost plus ten (10%) percent. That means that the carrier would reimburse the hospital \$9,900 for an implantable for which the hospital paid \$9,000. The carrier would use the MAR to determine whether the total bill reached the stop-loss threshold.” Joint Exhibit 8-9. Then, in February 2000, Dee Torres, an Information Specialist at the MRD, responded to a similar inquiry stating: “Audited charges are what’s left after appropriate reductions (such as costs + 10% for implants).” *Id.* For more than three (3) years the Commission staff maintained this interpretation as agency policy.

B. The Implant QRL

However, in October 2000, a different answer regarding implants was published in the format of a Question Resolution Log (“QRL”). A QRL is a tool intended for Commission employees to respond to common questions in medical fee disputes. A QRL is prepared by a team of Commission staff members who meet to draft an answer to a

common question and publish it in the QRL, but the QRL is not approved by anyone other than the QRL staff team. Joint Exhibit 9 at pp. 29-30. In response to a question about how the stop-loss exception applies to a \$55,000.00 hospital bill with \$20,000.00 in implant charges to the insurance carrier, QRL 01-03 stated: "the stop-loss threshold is determined by total audited charges" . . . and the amount due is "75% times the audited charges. In the instant case of \$55,000 X 75% = \$41,250 reimbursement to the hospital." Joint Exhibit 9-3. This QRL response contradicted the previous policy.

C. The First "Stop-Loss Exception Decision by SOAH

The first medical fee dispute case concerning the "stop-loss" exception was litigated at SOAH in February 2001 under SOAH Docket No. 453-00-2092.M4; *City of Fort Worth v. All Saints Hospital System and Texas Workers' Compensation Commission* (G. Cunningham presiding). It concerned an inpatient admission in July 1998. Julie Shank, the Commission's MRD director at the time the 1997 Guideline was developed, testified for the City of Fort Worth that the "stop-loss" exception was developed "to ensure hospitals were fairly reimbursed for unusually complex cases or unusually long admissions." Joint Exhibit 1-3-1, at p. 9. The City of Fort Worth presented the testimony of Robin Dennis, a senior Medical Reimbursement Analyst for the Texas Workers' Compensation Insurance Fund. Ms. Dennis testified that for a July 1998 admission, the services rendered during the admission "were not unusually costly or extensive." *Id.*

Administrative Law Judge (ALJ) Georgie Cunningham's April 2001 decision in

SOAH Docket No. 453-00-2092.M4; *City of Fort Worth v. All Saints Hospital System*, that the “stop-loss” exception did not apply to the disputed admission turned on her conclusion that implant charges could be audited to cost plus ten (10%) percent, which brought the audited charges below the \$40,000.00 minimum threshold. Joint Exhibit 1-3-1, at pp. 12-15. ALJ Cunningham reasoned: "Allowing hospitals to set their own charges for implantables and then removing carriers' abilities to audit charges, thereby forcing them to pay inflated bills, leads to absurd results." *Id.* at p. 10.

D. Other SOAH Decisions Regarding Implants

Several other early SOAH decisions turned on whether carriers are allowed to audit implant charges to cost plus ten (10%) percent when determining whether total audited charges exceed \$40,000.00. The majority of those decisions found that implants can be audited to cost plus ten (10%) percent.⁴ A minority of cases held that implants are not subject to such audit, despite the finding that “all charges” on a hospital bill are subject to audit.⁵

In July 2001, in SOAH Docket No. 453-01-1612.M4; *Facility Insurance Corporation v. Rio Grande Regional Hospital and Texas Workers' Compensation Commission*, the second SOAH decision to interpret the “stop-loss” exception, Ms. Shank again testified that the Commission policymakers' original intent regarding the “stop-loss”

4. See, e.g., Joint Exhibit 1-3-2, at p. 5; Joint Exhibit 1-3-3, at p. 4; Joint Exhibit 1-3-5, at p. 3; Joint Exhibit 1-3-6, at p. 10; Joint Exhibit 1-3-7, at p. 5; and Joint Exhibit 1-3-12, at p. 4.

5. Joint Exhibit 1-3-4, at p. 11; Joint Exhibit 1-3-9, at p. 8; and Joint Exhibit 1-3-10, at p. 5.

exception was to "ensure hospitals were fairly reimbursed for unusually complex cases or unusually long admissions." Joint Exhibit 1-3-2, at p. 3. For an admission in April 2000, Ms. Shank testified that "the present case was not uncommon, the services rendered were not unusually costly or extensive, and the admission was for only four days."⁶ *Id.*

But the other early SOAH decisions interpreting the stop-loss exception turned on whether implants could be audited to cost plus ten (10%) percent. Because total audited charges frequently fell below the \$40,000.00 minimum due to implants being audited to cost plus ten (10%) percent, the issue of whether a hospital admission was actually unusually extensive or costly was not reached until later SOAH decisions in 2003 and 2004.

II. The Two Prong Test.

The 1992 Hospital Fee Guideline also contained a "stop-loss exception." Joint Exhibit 13 at p. 6. Lisa Hannusch, the Division's expert witness at trial in this case (Joint Exhibit 13 at p. 125), worked at the Commission between 1990 and 1996 and served on the rulemaking committee for the 1992 Hospital Fee Guideline and the 1997 Guideline. Joint Exhibit 13 at p. 6-7. Ms. Hannusch's report confirmed the Commission's intent that the "stop-loss" exception was provided for truly unusual admissions as an exception to the

⁶ In December 2002, in SOAH Docket No. 453-03-0910 M4, *Zurich American Insurance Company v. Texas Workers' Compensation Commission and HealthSouth Medical Center*, Ms. Shank, who was also a registered nurse, Joint Exhibit 1-3-3, at p. 6, again testified that the surgery went as planned, "was not unusually long, and required the hospital to provide neither unusually extensive nor expensive services." Joint Exhibit 1-3-2 at p. 2.

standard admission. Joint Exhibit 13-1 p.3.

Ms. Hannusch's report confirmed that the Commission's intent regarding the "stop-loss" exception has always been the same: "The stop-loss methodology was provided for truly unusual admissions as an exception to standard admissions." Joint Exhibit 13-1, page 3; Joint Exhibit 13 at p. 24. According to Ms. Hannusch, application of the "stop-loss" exception required first that the admission be classified as unusually extensive and costly before the mathematical calculation of seventy-five (75%) percent could be applied to total audited charges. Joint Exhibit 13 at p. 22. Ms. Hannusch's position has never changed. In December 2004, Ms. Hannusch testified at SOAH that the stop-loss exception required a two prong test, consistent with her testimony in this case. Joint Exhibit 13 at pp. 11-12 and 26-27.

Between 1996 and 2002, Ms. Hannusch worked for what is now Texas Mutual Insurance Company (Texas Mutual), which at the time processed an average of 50,000 medical bills per month. Joint Exhibit 13 at p. 28. Ms. Hannusch testified that while at Texas Mutual, she witnessed an increase in hospital bills requesting stop-loss payment for standard admissions without any support for those admissions being unusually extensive and costly. Joint Exhibit 13 at p. 28.

Dr. Nicholas Tsourmas, Texas Mutual's Medical Director (RR 2-60), explained Texas Mutual's application of the two prong test in more detail. RR 2-73, 77. He reviews a hospital's medical records of an admission (RR 2-84), to determine whether unusually

costly or unusually extensive services were provided. RR 2-86. Dr. Tsourmas has made at least 900 such reviews. RR 2-85.

Dr. Ron Luke founded Forte, a Texas workers' compensation medical bill audit company used by insurance carriers to conduct hospital bill reviews. RR 2-106, 107. Forte reviewed hospital bills to determine whether services were unusually extensive and costly as early as 2002. RR 2-109. In general, hospitals did not dispute reimbursement at the per diem rate if Forte's doctor concluded the services were not unusually extensive and costly. RR 2-109, 10.

At the same time as insurance carriers were applying the two-prong test, Vista Medical Center Hospital sought and obtained a statement regarding implant charges from a low-level Texas Workers' Compensation Commission employee. In August 2002, Raegan B. Brown, a Medical Review Division "Information Specialist II," responded to a letter from Vista Medical Center Hospital's lawyer Christina Gutel, who had requested clarification on how implant charges are to be treated under the stop-loss exception. Joint Exhibit 9-4. Ms. Brown's letter stated that carriers should audit bills on a line-by-line basis and reduce charges to "usual and customary." Joint Exhibit 9-4 at p. 1. Ms. Brown defined "usual and customary" charge as "the provider's *usual* charge within the *customary* range of fees charged by others in the geographic locality that are *reasonable* based on the medical circumstances." (emphasis in original). Joint Exhibit 9-4 at p. 2. The letter concluded that the 1997 Guideline does not allow implants to be carved out and reimbursed

at cost plus ten (10%) percent unless it is first determined that the per diem method applies. Joint Exhibit 9-4 at p. 2-3.

A. Early Medical Review Division Actions on Unusually Extensive

Despite Ms. Brown's letter to Vista Medical Center Hospital, some Medical Dispute Resolution Officers (MDROs) had understood the Texas Workers' Compensation Commissioners' intent that application of the stop-loss exception required unusually extensive services. In November 2002, MDRO Carolyn Ollar sent an e-mail to David Martinez, Medical Dispute Resolution (MDR) Section Manager, regarding a proposed advisory discussing the stop-loss exception. Ms. Ollar's email shows the importance of a two prong test: "The other thing we might consider is whether or not these surgeries actually qualify for 'unusually costly services' though I am not sure what criteria we would use. Maybe a review of the explanation of any unusual circumstances resulting in the increased charges and supporting documentation. Back surgeries are done every day and most do not exceed the \$40,000 threshold. It would appear that this was meant for treatment such as burns, catastrophic injuries, etc. and that some providers have taken it as a free license to grossly inflate their implants to make a windfall profit." Joint Exhibit 8-19.

The two prong test explicitly appeared in at least one Medical Review Division decision. In December 2002, in MDR Tracking No. M4-02-4447-01, the MDRO stated:

“Two of the criteria that must be met to establish entitlement to stop-loss reimbursement are: 1. audited charges in excess of \$40,000.00, and 2. the services provided should be unusually extensive/costly. While the provider did bill in excess of \$40,000.00, the documentation does not indicate any services that are unusually extensive or costly. The carrier was correct in basing its reimbursement on the per diem methodology in #1 above. Therefore, no additional reimbursement is recommended.” Joint Exhibit 1-1 (97-05 00034); Joint Exhibit 8-19.

B. Early Medical Review Division Actions on Implants

Initially, it was held that implants should be audited and paid at cost plus ten (10%) percent whether the admission was paid under the per diem or the stop-loss exception. Joint Exhibit 1-1 (97-05 00008). For example, in January 2003, in MDR Tracking No. M4-02-4795-01, the MDRO decided that the hospital was not entitled to reimbursement for implants at seventy-five (75%) percent of billed charges: “The carrier has submitted one purchase order that indicates evidence of the cost of the implants. The total indicated is \$4,830 for implants. The provider indicates on the submitted UB-92 a total charge of \$22,668.00 for the total cost of the implants. Based on the information provided by the requestor, it would not appear that effective cost control has been achieved by a 500% mark-up on the implants.” Joint Exhibit 1-1 (97-05 00034).

Within a few months, the position communicated by Raegan Brown to Ms. Gutel appeared as an MDRO rationale to disallow auditing implants to cost plus ten (10%)

percent. For example, in March 2003, in MDR Tracking No. M4-02-4514-01, the MDRO found as follows: “The carrier should audit the entire bill to see if the charges represent ‘usual and customary’ amounts. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implants in the same geographical region as the hospital. Even if the charge appears to be inflated based on an invoice or based on information from the fee guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities.” Joint Exhibit 1-1 (97-05 00038).

MDROs continued to disallow auditing implants to cost plus ten (10%) percent, even though insurance carriers had successfully litigated this issue at SOAH. For example, in June 2003, in MDR Tracking No. M4-03-1610-01 and various other MRD decisions, additional reimbursement was awarded to the hospital because implants were not allowed to be reduced to cost plus ten (10%) percent and because, according to the MDRO, SOAH precedent supporting the carrier’s auditing and reimbursement practice “are not consistent with Commission rules.” Joint Exhibit 1-1 (97-05 00182). Some later MDRO decisions again reversed course. In November 2003, in MDR Tracking No. M4-03-1223-01, the MDRO held that the stop-loss exception did not apply to a particular admission because reducing implants charges to cost plus ten (10%) percent resulted in total audited charges below \$40,000: “The requestor’s bill without implants is \$26,872.60; the total cost plus ten (10%) percent for the implants is \$4,796.00 (\$4,360 + \$436 (10% mark up); total amount

of the hospital bill is \$31,668.60; therefore, per the Acute Care Inpatient Hospital Fee Guideline 134.401(c)(1) the standard per diem amount of \$1,118 will be used.” Joint Exhibit 1-1 (97-05 00137).

C. Early SOAH Decisions on Unusually Extensive

Despite the mounting MRD decisions made on the basis of implant charges, SOAH was reaching decisions based on the absence or existence of unusually extensive services. After ALJ Cunningham's 2001 Decisions raised the issue of unusually extensive services, a number of other SOAH ALJ decisions issued in 2003 and 2004 concluded that the stop-loss exception did not apply unless the hospital demonstrated that the services provided were unusually costly or unusually extensive.⁷ Some other ALJs in 2004 reached the opposite result.⁸ Some ALJs ruled against carriers despite acknowledging the absurdity of the hospitals' arguments. For example, in November 2004, in SOAH Docket No. 453-04-3600.M4, the hospital's markup for implant charges was one thousand (1000%) percent, but ALJ Church still found held that carriers may not audit implant charges to cost plus ten (10%) percent (Joint Exhibit 1-3-9, at p. 8), and that there is no separate requirement that an admission be unusually extensive and costly. *Id.* at p. 7. Judge Church stated: "Carrier's

⁷ See, e.g., Joint Exhibit 1-3-2, at p. 5 (“The stop-loss methodology is to ensure fair and reasonable compensation for unusually costly services or unusually extensive services.”); Joint Exhibit 1-3-3, at p. 6 (admissions that exceed the \$40,000 threshold do not have an “unqualified right” to receive payment under the stop-loss exception); Joint Exhibit 1-3-5, at p. 4 (“reimbursement under the stop-loss provisions is not an automatic right that vests every time a bill tops \$40,000”); Joint Exhibit 1-3-6, at p. 6.

⁸ See, e.g., Joint Exhibit 1-3-10, at p.7; Joint Exhibit 1-3-9, at p. 7.

argument that this rule tips the balance too far away from cost containment may carry considerable weight in another forum, but it lacks merit here." *Id.* at p 6.

D. Vista

Vista Medical Center Hospital ("Vista") is a 37 bed specialty hospital in Pasadena, Texas which accounts for the majority of the alleged stop-loss exception disputes with insurance carriers. Before the arrival of Vista, which was completed in 1999 (Joint Exhibit 5-15), there were few disputes regarding the application of the stop-loss exception in the 1997 hospital fee rule, perhaps because in 1997 only 3% or 4% of hospital admissions had billed charges in excess of \$40,000. Joint Exhibit 4; RR 2-135. Beginning in 2003, the number of alleged stop-loss exception disputes increased significantly. Joint Exhibit 2-1 at p. 7 (page 5 of the Order). Between 2003 and August 31, 2005, approximately 885 stop-loss exception cases were sent to SOAH for contested case hearings – 497 of those cases involved Vista. Joint Exhibit 2-1 at p. 7 (page 5 of the Order). Between February 2005 and June 2006, the MRD decided almost 1,500 stop-loss exception disputes – about 640 of those cases involved Vista. Texas Mutual's ("TMIC") Exhibit 22.

Vista's business model is built on "increased amounts of reimbursement for the same or similar procedure, as compared to other health care providers," by avoiding payors that "limit reimbursement." TMIC Exhibit 2 at p. 31. In 2006, in 86% of its workers' compensation cases, Vista charged more than \$40,000. TMIC Exhibit 1 at p. 13. Vista acknowledged this business model as early as 2003. Phillip Chan, the CEO of Dynacq

Healthcare, Inc., the parent company of Vista stated: "Every patient walking into this hospital is going to have a procedure, and the procedure is going to be expensive.' He went on to explain: 'Our average bill going out to insurance companies is around \$50,000. That's what accounts for the revenue per bed.'" Joint Exhibit 5-15. According to Dynacq's SEC filings cited by *Barron's* "Vista Medical Center Hospital is an institution that is particularly affected by the Stop-loss provisions as most of the surgery cases require intensive care and although the hospital stays are brief, a great deal of services are rendered within that time." *Id.*

1. Vista's Charges for Implants, Services and Supplies

Vista's billed charges are the result of hefty markups over cost for implants, for services and for supplies. Vista's standard markup schedule for implants is four hundred (400%) percent. Joint Exhibit 6 at p. 67. The record contains one Vista stop-loss exception claim against Texas Mutual from 2001, in which an implant invoice to Vista for \$10,274.00 became an implant charge by Vista for \$41,096.00. TMIC Exhibit 3. Under Vista's interpretation of the stop-loss exception, and the holding of Travis County District Judge Margaret Cooper, this one line item charge for implants made it entitled to seventy-five (75%) percent of its charges for the entire admission, which in this case exceeded \$200,000.00. For services, Vista's *hourly* charges for preop (more than \$1,000.00), operating room (more than \$2000.00), anesthesia (nearly \$2,000.00) and recovery room (\$2,990.00) far exceed the 1997 Guideline's *daily* surgery admission fee of \$1,118.00.

TMIC Exhibit 1 at p. 4. On an actual 3-day admission the 1997 Guideline's total fair and reasonable payment would be \$3,354.00, compared with Vista's time-based charges for just preop, operating room, anesthesia and postop, totaling nearly \$40,000. TMIC Exhibit 1 at p. 5. Vista's markups for supplies are between 500% (Joint Exhibit 6 at p. 69) to 40,833.00%. TMIC Exhibit 16.

2. The Vista Consolidated Docket Before ALJ Ramos

In the spring and summer of 2003, the Commission was issuing more and more adverse MRD decisions against Vista Medical Center Hospital. Vista appealed these cases to SOAH where at least one of those cases was assigned to be tried by ALJ Sarah Ramos. Joint Exhibit 2-3 at p. 1. In July 2003, Texas Mutual, along with Hartford Insurance Company, and Healthcare Corporation\Health South Corporation\ESIS moved to consolidate SOAH cases between the carriers and Vista. *Id.* ALJ Ramos consolidated the cases and approved a list of threshold legal issues, including whether implants could be audited to cost plus ten (10%) percent, and whether the hospital must show an admission is unusually extensive and costly before triggering stop-loss exception reimbursement. *Id.* at p. 4-17. To provide context for and understand the consequences of the parties' competing interpretations, ALJ Ramos allowed the parties to conduct extensive fact and expert discovery relevant to the threshold legal issues. Joint Exhibit 5-2; Joint Exhibit 5-4 to Joint Exhibit 5-6; and Joint Exhibit 5-17 to Joint Exhibit 5-23; RR 2-130.

The carriers and Vista briefed the threshold legal issues with reference to the

evidence gathered from Vista's witnesses and Carriers' witnesses. Joint Exhibit 2-3 at p. 2. At the same time that the carriers and Vista were litigating threshold legal issues before ALJ Ramos, SOAH ALJ Howard Seitzman decided to consolidate all other stop-loss exception medical fee disputes referred from the MRD between all carriers and all Texas hospitals. Between December 2004 and January 2006, ALJ Seitzman collected more than 885 stop-loss exception cases into the "Stop-Loss Docket." Joint Exhibit 2-1 at p. 8 (page 5 of the Order). These cases would later be subject to the rulings of the *En Banc* Panel, discussed below.

Back at the Texas Workers' Compensation Commission ("TWCC" or "Commission"), the MDR Director began to take notice of the confusion, especially among its MDROs. Joint Exhibit 9 at p. 44. For example, in a 2004 lawsuit filed by Bayshore Medical Center against the TWCC over an alleged back-log of stop-loss exception cases pending at the MRD, the TWCC responded to interrogatories about the reason that it had not issued advisories regarding the stop-loss exception: "[D]ue to different interpretations of the provisions of TWCC Rule 134.401 regarding reimbursement to hospital's claims for charges exceeding \$40,000 in the State Office of Administrative Hearings (SOAH) cases and in several appeals currently pending in the state district courts, TWCC has not considered the issuance of any such Advisory until further experience with these cases occurs." Joint Exhibit 9-17 at p. 19. Bayshore took the deposition of David Martinez in September 2004. When the deposition began, Mr. Martinez' title was Manager of Medical

Dispute Resolution. The deposition was continued to another day, and Mr. Martinez' position at TWCC had changed to Manager of Medical Quality Review. Joint Exhibit 8.

Mr. Martinez's deposition answers showed that he did not agree with the 2 prong test position taken by TWCC policy-makers such as Julie Shank, Lisa Hannusch, and later, Allen McDonald.

Q: Now, if we are applying this rule literally, wouldn't one inquiry in every stop-loss case be is this an unusually costly or lengthy stay?

A: No.⁹

* * *

Q: And what is it you disagree with in the sentence that we read or I read about the two criteria that must be met to establish an entitlement to stop-loss reimbursement?

A: The \$40,000 does establish an unusually extensive or costly – that's the threshold amount for application of a stop-loss reimbursement method.¹⁰

Mr. Martinez relied heavily on auditing to "usual and customary" charges, but Mr. Martinez also could not explain what TWCC expected carriers to do when auditing charges to "usual and customary."

Q: Mr. Martinez, I've handed you Exhibit 17. Have you seen this letter before?

A: I believe so.

Q: And it's a letter from Raegan Brown at the Commission to Christian Gutel at Vista Medical Center Hospital, correct?

9. Joint Exhibit 8 at p. 82-83.

10. Joint Exhibit 8 at p. 91-92.

A: Yes.¹¹

* * *

Q: And it talks here about the customary range of fees charged for the service by others that are reasonable, and reasonable is in italics. Does this mean that the carrier is to make its own determination of which of the range of fees are reasonable fees and which are not in applying this audit provision?

A: I couldn't tell you what Ms. Brown meant by that.¹²

* * *

Q: Where in the language of the rule itself . . . does it say that you audit – or that usual and customary means the range of reasonable charges imposed by other providers in the geographic area?

A: Where does it say in the rule? I don't believe it addresses that.¹³

* * *

Q: Is the definition of usual and customary set forth in that letter the Commission's current definition of the term usual and customary?

A: It's – it's the response to concern from a health care provider. I wouldn't say it's a definitive. It depends on the – well, it's what it is. It's – it's written to – as it's written.¹⁴

* * *

Q: Mr. Martinez, when a carrier is reviewing a hospital's charges and trying to determine whether those charges exceed usual and customary, by how much does that hospital's charges have to exceed other hospitals' charges before the

11. Joint Exhibit 8 at p. 120.

12. Joint Exhibit 8 at p. 123.

13. Joint Exhibit 8 at p. 146-47.

14. Joint Exhibit 8 at p. 173.

charge is no longer considered usual and customary?

A: I don't know.¹⁵

* * *

Q: Has the Commission ever informed the system participants how it defines the term usual and customary?

A: You already asked that. I don't believe so.¹⁶

After Mr. Martinez' deposition, TWCC policymakers became even more aware of the confusion within the agency and put a hold on issuing further decisions. In December 2004, Bob Shipe, TWCC Executive Director, responded to a letter from attorney James Loughlin regarding the stop-loss exception. Mr. Shipe stated: "Medical Review staff have been carefully reviewing the application and interpretation of the 'stop-loss' provisions and that review will be completed prior to the end of January 2005. During the interim period, the Medical Review dispute resolution team has temporarily suspended the issuance of decisions in 'stop-loss' cases." Joint Exhibit 9-18.

Mr. Martinez's role as supervisor of the MDROs ended when Mr. Allen McDonald became the MRD Director. One of Mr. McDonald's concerns was with the inconsistent interpretation and application of the stop-loss exception. Joint Exhibit 9 at p. 44. According to the trial testimony of Allen McDonald, during Mr. Martinez's tenure as MDR supervisor, he instructed MDRO's to decide stop-loss exception cases under a one prong

15. Joint Exhibit 8 at p. 181.

16. Joint Exhibit 8 at p.183.

test, even if they thought it was a two prong test.

Q: And what forces or factors led the stop-loss issue . . . to come to the forefront of your day-to-day operations?

A: The reason they came to the forefront, initially I had medical dispute resolution officers approach me and tell me that the agency has been doing it wrong and they were given specific instructions on what to do, how to write, and they weren't being given an opportunity to discuss the rule; they were being told "This is the way it's going to be done, you do it." So that was the initial thing that brought it up.

Q: Let's focus on that. What did you understand with the phrase "doing it wrong." What was being communicated to you?

A: The medical dispute resolution officers told me that their supervisor told them they either do it this way or they would see impact on their performance evaluations.

Q: Define "this way."

A: A mathematical calculation, solely looking at \$40,000, and issue the orders in that manner.

Q: Was there a sense that there was another component beyond mathematical?

A: Certain medical dispute resolution officers believed that there was.

Q: And did those officers believe? Define the other component.

A: The main issue with the other component is looking at unusually extensive services.¹⁷

The Commission's highest policymakers became involved in trying to resolve the confusion over stop-loss exception in January 2005. Joint Exhibit 1-6. At the TWCC Public Meeting on January 20, 2005, in response to a question about the stop-loss exception

17. RR 2- 206 to 207.

from TWCC Chairman Mike Hachtman, TWCC Executive Director Bob Shipe stated: “We acknowledge that even within the Commission there is confusion about how that rule is to be interpreted. . . . We identified the problem back in November that it was just getting out of control, even our own interpretation, and we put a stop to issuing any decisions on stop-loss until we get a better handle on it. And, some consistency is what we are really looking for. Consistency in interpretation of our own rule and the statute.” At that meeting, the Commissioners asked Mr. McDonald and his Staff to look at developing a way to ensure that there is a more consistent and appropriate application of the rule within the agency’s decisions. Joint Exhibit 1-6.

At TWCC's February 17, 2005 Public Meeting, Allen McDonald presented the requested report¹⁸ on the stop-loss exception. Mr. McDonald began by acknowledging that there “have been periods of inconsistencies both internally in what we have done as well as with the State Office of Administrative Hearings in the decisions they have issued.” Mr. McDonald explained that in the preamble to the 1997 HFG, “the Commission flat-out rejected charge-based reimbursement schemes or methodologies as an adequate way to establish fee schedules in the workers’ compensation system.” Joint Exhibit 1-6.

Mr. McDonald stated “when reading a rule . . . everything about the format means something.” * * * “So when you look at the way the rule (28 TEX. ADMIN. CODE §134.401(c)(6)) is formatted and the way it’s written when you get into paragraph 6, which

18. The Staff Report of February 17, 2005. Joint Exhibit 7-3.

is explained in subparagraph (A) and clauses (i) through (v). Those clauses are independent statements that control the application of paragraph 6. The first one is where that \$40,000 came from. But if you read that second one, it also says, there has to be unusually extensive services. So the way this rule is written the threshold that's being established is that paragraph 6 says stop loss method is for unusual costly services and to determine unusually costly services you must look at one the charge \$40,000 or greater, and you have to consider whether there was unusually extensive services in the hospital.” Joint Exhibit 1-6.

This February 17, 2005, Staff Report interpreted the 1997 Guideline's stop-loss exception language as follows:

Rule 134.401(c)(6) establishes that the stop-loss method is to be used for 'unusually costly services.' The explanation that follows this paragraph indicates that in order to determine if 'unusually costly services' were provided, the admission (or hospital stay) must not only exceed \$40,000 in total audited charges, but also involve 'unusually extensive services.'

Joint Exhibit 4.

Obviously the Commissioners did not believe they had to treat the Staff Report as a proposed administrative rule, because the Staff Report did not change the 1997 Guideline! The Staff Report was a logical and legally valid interpretation of the 1997 Guideline. The interpretation met the Commission's intent that the stop-loss exception was limited to a minuscule number of admissions involving “unusually costly services” or “unusually extensive services.”

Unlike earlier interpretations of the stop-loss exception, the Commission's interpretation as expressed in the Staff Report was not the product of an individual MDRO or a letter written by an individual staff employee without any indication of whether it was reviewed and approved by agency management. " Joint Exhibit 1-6.

After presentation of the Staff Report at the Commission's February 17, 2005, public meeting, it was then published on the Commission's web site (Joint Exhibit 9 at p. 8), and in an MDR newsletter. Joint Exhibit 9-10. In addition, after the Staff Report's presentation and publication on the TWCC's website, the interpretation as expressed in the Staff Report was applied to all stop-loss exception cases pending at the MRD. Joint Exhibit 9 at p 48. The Staff Report interpreted the 1997 Guideline stop-loss exception consistent with the original interpretation and application by the Commission.

After briefing the threshold legal issues to ALJ Ramos, including the effect of the Staff Report, in May 2005 ALJ Ramos held a hearing between Vista and the carriers. Joint Exhibit 2-3 at p. 4. Thirty-six exhibits, including four depositions, were admitted into evidence, and two witnesses testified at the hearing. Joint Exhibit 2-3 at p. 2. In November 2005, ALJ Ramos issued her decision in the Vista consolidated docket. Her Order No. 14 -- On Threshold Legal Issues -- holds that carriers are permitted to audit implants to cost plus ten (10%) percent (Joint Exhibit 2-3 at p. 9-10), and that application of the stop-loss exception requires two prongs or triggers: (1) audited charges in excess of \$40,000.00 and (2) an admission that is unusually costly and extensive. Joint Exhibit 2-3 at p. 16.

After ALJ Ramos issued her ruling on threshold legal issues, Vista and Texas Mutual tried the other cases between them that were on the Ramos docket on stipulated facts. These cases were decided consistent with ALJ Ramos' holdings on the threshold legal issues. For example, in one of those cases, ALJ Ramos held that Vista was not entitled to stop-loss reimbursement for an admission which had originally occurred in February 2002, because implants charges audited to cost plus ten (10%) percent reduced total audited charges to below \$40,000.00. Joint Exhibit 1-3-14 at p. 5.

In SOAH Docket No. 453-03-2412.M4; *Vista Medical Center Hospital v. Texas Mutual Insurance Company* (which was issued after the *En Banc* Panel's rulings, discussed below), ALJ Ramos applied her threshold legal issue rulings to conclude that Vista was not entitled to stop-loss reimbursement for an admission which had originally occurred in 2001, because the admission was not unusually extensive and costly. Joint Exhibit 1-3-18 at p. 10. In the decision, ALJ Ramos noted that Vista's charges exceeded \$40,000.00 only because it had inflated its charges for typical hospital services. Joint Exhibit 1-3-18 at p. 10.

3. Stop-Loss Docket Before the En Banc Panel

In January 2006, ALJ Howard Seitzman announced that the Stop-Loss Docket, containing approximately 885 other alleged stop-loss exception cases, had been assigned for adjudication of threshold legal issues to an *En Banc* Panel of 9 SOAH ALJs. Joint Exhibit 2-1 at p. 8 (page 5 of the Order). As it had in the cases consolidated before ALJ

Ramos, Texas Mutual and other carriers tendered the evidence of Dr. Luke and Dr. Tsourmas, to show the Panel the consequences of the parties' competing interpretations. The Panel, however, denied such evidence. Appendix 2, Consolidated Order No. 4 Memorializing Prehearing Conference and Issuing Briefing Outline. In November 2006, after extensive briefing by the Hospitals, Texas Mutual, and this time, the Texas Department of Insurance, Division of Workers' Compensation, the *En Banc* Panel heard oral argument on the threshold legal issues. Joint Exhibit 2-1 at p. 9 (page 6 of the Order). In the briefing and at argument, the Carriers and the Division argued why application of the stop-loss exception required a two prong or trigger test of (1) total audited charges in excess of \$40,000.00, and (2) unusually costly or unusually extensive hospital admission. Joint Exhibit 2-1 at p. 20-21 (pages 17 and 18 of the Order).

In January 2007, the *En Banc* Panel issued its decision on threshold legal issues. The Panel concluded that implant charges may not be audited to cost plus ten (10%) percent (Joint Exhibit 2-1 at p. 10 (page 7 of the Order), and that application of the stop-loss exception only requires that the hospital's bill exceed \$40,000 in total audited charges. Joint Exhibit 2-1 at p.18 (page 15 of the Order). The Panel found that hospitals are not required to show that an admission is "unusually extensive and costly,"(Joint Exhibit 2-1 at p.18 (page 15 of the Order)), and that the Staff Report is inconsistent with prior MRD decisions and the Division of Workers Compensation's rules and preambles. Joint Exhibit 2-1 at p. 25 (page 22 of the Order). The *En Banc* Panel held the 1997 Guideline

“*unambiguously* requires application of the stop-loss reimbursement methodology when total audited charges for an admission exceed the \$40,000 Stop-Loss Threshold,” (Joint Exhibit 2-1 at p. 22-23 (pages 19 and 20 of the Order)(emphasis added), the Stop-Loss Threshold is designed as a *clear standard* for determining when an admission satisfies those concerns,” (Joint Exhibit 2-1 at p. 23 (page 20 of the Order)(emphasis added), and the Stop-Loss Rule *is not ambiguous*” Joint Exhibit 2-1 at p. 27 (page 24 of the Order)(emphasis added). In a subsequent letter clarification of the ruling, the Panel stated that the phrase "the hospital's usual and customary charges" means the hospital's own usual and customary charges, and not to charges that are a median or average of charges in a geographic area. Joint Exhibit 2-2.

Beginning in the Spring of 2007, and continuing through the spring of 2008, ALJs at SOAH have held "summary disposition" hearings, applying the *En Banc* Panel's threshold legal issue rulings to adjudicate the individual stop-loss exception disputes in the Stop-Loss Docket. During those hearings, carriers are not permitted to contest whether an admission is unusually extensive or costly, show the gross mark-ups for implants and services, or dispute whether the hospitals' charges are in line with other facilities. Orders from these summary disposition hearings have been issued and appealed to the Travis County District Court by numerous carriers. *E.g.*, Joint Exhibit 3-1 to 3-6.

4. The Stop-Loss Exception Declaratory Judgment Before Judge Margaret Cooper

Zenith Insurance Company (“Zenith”) filed a declaratory judgment lawsuit against the Texas Workers’ Compensation Commission in January 2005, seeking a declaration that the stop-loss exception was invalid on a number of grounds. RR 1-30-31. Two years later, Vista filed a declaratory judgment lawsuit seeking a declaration that the Staff Report was an agency rule that had not been validly adopted under the Texas Administrative Procedure Act. CR 3:185.

Texas Mutual filed an answer and a counterclaim seeking declarations that the 1997 Guideline, properly interpreted: (1) requires billed charges for implants to be reduced to cost plus ten (10%) percent before determining whether an admission meets the \$40,000 minimum stop-loss threshold; and (2) requires a hospital to demonstrate that the services provided in that admission were unusually costly and unusually extensive before the hospital is entitled to stop-loss exception reimbursement. Alternatively, Texas Mutual sought a declaration that the stop-loss exception is invalid because: (1) it violates Labor Code Section 413.011(d) because it is not designed to achieve effective medical cost control; and (2) it is an unconstitutional delegation of the Commission’s power to set medical fees to private parties. CR 17: 996. Zenith intervened in this suit. RR-1-6.

Zenith based its claim for declaratory relief on the fact that the stop-loss exception failed to conform to a Legislative mandate that fee guidelines use Medicare based reimbursement methodologies and that the Commission, now Division failed to review and

revise the \$40,000 stop-loss threshold, despite a Legislative mandate that fee guidelines be reviewed at least every two years.

Other parties also intervened and sought declaratory relief regarding the application and validity of the stop-loss exception. *See, e.g.*, CR: 1042.

After trial, Judge Margaret Cooper entered a Final Judgment on November 6, 2007, declaring: (1) that a hospital is entitled to payment under the stop-loss exception when total audited charges exceed \$40,000; (2) there is no additional requirement that the hospital prove that the services provided during the admission be unusually costly or unusually extensive; and (3) that the Staff Report is an invalid administrative rule.

Judge Cooper, by denying the relief sought and requested by the insurance carriers found that: (1) the stop-loss exception, as interpreted, does not violate the Labor Code; (2) is not an unconstitutional private delegation; (3) did not have to be reviewed or revised as mandated by the Legislature; and (4) did not, after 2002, have to utilize Medicare reimbursement methodologies. CR: 1343. The Division has chosen not to appeal the trial court's interpretation of the stop-loss exception or its invalidation of the Staff Report.

5. Post Final Judgment Division Actions

On December 28, 2007, the Division finally adopted a new Hospital Fee Guideline to replace the 1997 Guideline. As required by House Bill 2600, the new Hospital Fee Guideline is based on Medicare reimbursement methodologies. Under the new Hospital Fee Guideline, inpatient admissions are paid at 143% of Medicare with implants included,

or 108% of Medicare with implants carved out at cost plus ten (10%) percent not to exceed \$1,000 per item and \$2,000 per admission. The new Hospital Fee Guideline applies to all services provided to workers' compensation patients in an inpatient hospital on or after March 1, 2008. According to the new Hospital Fee Guideline, the 1997 Guideline, and its stop-loss exception, continues to apply to services provided before March 1, 2008. 28 TEX. ADMIN. CODE § 134.404(a)(2).

However, in February 2008, the Division proposed the repeal of the 1997 Guideline, saying it was "no longer necessary" for making reimbursement determinations. 33 Tex. Reg. 1487 (February 22, 2008). Texas Mutual and the Insurance Council of Texas ("ICT") filed comments supporting the repeal, but asked the Division to make it more explicit in the repeal language that the repeal of the 1997 Guideline applies to all pending stop-loss exception cases, whether at the Division, SOAH, Travis County District Court or on appeal in the appellate courts. Appendix 3, Comments of Texas Mutual and ICT. Instead of adjudicating the pending cases under the repealed 1997 Guideline, Texas Mutual and ICT, among others, argued that reimbursement decisions for pending cases will be made under the Division's default rule, 28 Tex. Admin. Code §134.1; Appendix 4, Comments of John D. Pringle.

SUMMARY OF THE ARGUMENT

The Texas Workers' Compensation Commission was required to design fee guidelines that provided fair and reasonable reimbursements. The Act and Texas Workers'

Compensation Commission's ("Commission") rules require insurance carriers to make fair and reasonable reimbursements. When adopting the 1997 Acute Care Inpatient Hospital Fee Guideline, the Commission rejected a payment method based on a percentage of billed charges because paying a percentage of billed charges failed to provide effective medical cost control.

Although agency rules require that insurance carriers retrospectively review all complete medical bills line by line and pay for or deny payment in accordance with the Act, agency rules, and the appropriate fee and treatment guidelines in order to make fair and reasonable reimbursements, the Commission, some SOAH Administrative Law Judges and the Travis County District Court have limited the insurance carriers' audit powers contravening agency rules and the specific statutory provisions of Labor Code Section 413.011(d).

Evidence at trial showed few patients today ever pay a hospital's full charges due to the prevalence of Medicare, Medicaid, HMOs and private insurers who pay discounted rates. The Travis County District Court's holding that insurance carriers are to pay seventy-five (75%) percent of audited charges contravenes Labor Code Section 413.011(d). The Commission and the Texas Department of Insurance, Division of Workers' Compensation, and some SOAH Administrative Law Judges apply the 1997 Guideline's stop-loss exception as an entitlement and simply award seventy-five (75%) percent of the billed charges and disregard any evidence of what a fair and reasonable reimbursement

would be under the statutory standards. The Travis County District Court's holding affirms this treatment of the 1997 Guideline stop-loss exception as an entitlement to payment under a percentage of billed charges payment method.

ARGUMENT

ISSUE

The stop-loss exception to the Acute Care Inpatient Hospital Fee Guideline (28 Tex. Admin. Code §134.401(c)(6)) is invalid as construed by the District Court because the exception fails to provide for fair and reasonable reimbursement, conflicts with Texas Labor Code Section 413.011, is not Medicare based, and was not reviewed every two years.

I. Fair and Reasonable Reimbursement.

The Texas Labor Code requires reimbursement to hospitals to be fair and reasonable. TEX. LAB. CODE §413.011. Likewise, to ensure fair and reasonable reimbursements are made to hospitals, the Texas Workers' Compensation Commission "is given the burden of designing a fee guideline that provides fair and reasonable reimbursements, ensures the quality of medical care, and simultaneously achieves effective medical cost control." *All Saints Health Sys. v. Tex. Workers' Comp. Comm'n*, 125 S.W.3d 96, 100 (Tex. App. - Austin 2003, pet. denied).

The standard for establishing fee guidelines is found in Texas Labor Code § 413.011(d).

Fee guidelines must 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 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 commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

Current Texas Department of Insurance, Division of Workers' Compensation Rule

134.1(f) provides:

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.

28 Tex. Admin. Code §134.1(f).

Predecessor Rule 134.1(c), a Texas Workers' Compensation Commission rule, required that, in the absence of a specific fee guideline, the statutory standards in Texas Labor Code § 413.011 govern reimbursement for services not identified in an established fee guideline and shall be reimbursed at fair and reasonable rates until such period that specific fee guidelines are established by the Commission. 27 Tex. Reg. 4047 (May 10, 2002), proposed 26 Tex. Reg. 10785 (December 28, 2001).

The Texas Workers' Compensation Commission defined fair and reasonable reimbursement in rule 133.1(a)(8) as:

Reimbursement that meets the standards set out in § 413.011 of the Texas Labor Code, and the lesser of a health care provider's usual and customary charge, or

(A) the maximum allowable reimbursement, when one has been established in an applicable Commission fee guideline,

(B) the determination of a payment amount for medical treatment(s) and/or service(s) for which the Commission has established no maximum allowable reimbursement amount, or

(C) a negotiated contract amount.

25 Tex. Reg. 2126 (March 10, 2000), proposed 24 Tex. Reg. 10286 (November 19, 1999).

The Texas Department of Insurance, Division of Workers' Compensation amended Rule 133.1 on April 28, 2006, and removed the foregoing language in subsection (a)(8), for the most part, to 28 Tex. Admin. Code §134.1(f); 31 Tex. Reg. 3560 (Apr. 26, 2006).

The Texas Workers' Compensation Commission's former rule 133.304(i) required insurance carriers to make fair and reasonable reimbursements to health care providers for their services and treatments when there was no maximum allowable reimbursement (MAR). *Tex. Workers' Comp. Comm'n v. Patient Advocates*, 136 S.W.3d 643, 656 (Tex. 2004); 24 Tex. Reg. 10286 (1999), adopted 25 Tex. Reg. 2128 (2000), amended by 30 Tex. Reg. 7621 (2005) (emerg. rule); adopted 31 Tex. Reg. 3544 (2006). Legislative and agency policy has consistently provided that insurance carriers make fair and reasonable reimbursements to hospitals.¹⁹ The Texas Workers' Compensation Commission has defined "fair and reasonable reimbursement" to mean a reimbursement that meets the

19. See Texas Labor Code Section 409.0091(h) which became effective on September 1, 2007, providing for fair and reasonable reimbursements when there is no fee guideline.

standards set out in Texas Labor Code Section 413.011. *Tex. Workers' Comp. Comm'n v. Patient Advocates*, 136 S.W.3d at 656.

II. The 1997 Hospital Fee Guideline.

When adopting the 1997 Guideline, the Texas Workers' Compensation Commission noted that hospitals had sued "to invalidate each and every hospital fee guideline adopted by the Industrial Accident Board or the Commission." 22 TEX. REG. 6264, 6276 (July 4, 1997).²⁰ Thus, the Commission made a concerted effort to explain its reasoning in the preamble to the 1997 Guideline. *See generally*, 22 TEX. REG. 6264. Of particular relevance here is Commission's discussion of the alternatives considered and why they were not adopted.

Some inpatient payment methodologies considered by the Commission used the hospital's charges as a basis for determining payments. The Commission consistently rejected such methodologies because they "would allow the hospitals to affect their reimbursement by inflating their charges." *Id.* at 6268-69. If a fee guideline allows a hospital to increase its reimbursements simply by increasing its charges, then such a rule cannot achieve *effective* medical cost control as is statutorily required. 22 TEX. REG. at 6276.

One alternative considered was a supposedly "cost-based" reimbursement methodology. But it used hospital *charges* to determine "costs." *Id.* at 6276. The

20. The Texas Industrial Accident Board was the predecessor agency to the Texas Workers' Compensation Commission. *Texas Workers' Compensation Commission v. Garcia*, 893 S.W.2d 504, 511-14 (Tex. 1995).

Commission found that under this methodology, “a hospital can independently affect its reimbursement without its costs being verified.” *Id.* Relying on statements by the hospitals themselves, the Commission found that hospital charges were “basically meaningless in the current managed care environment.” *Id.* at 6303. The Commission found that these meaningless charges were not a valid indicator of hospital costs. For example, charges for surgical admissions had soared by 107% during a period in which costs increased only 16% as measured by the Consumer Price Index. 22 TEX. REG. at 6276. Thus, the supposedly “cost-based” methodology was rejected as inconsistent with “the statutory objectives of achieving effective medical cost control” and of not paying more than is paid on behalf of persons with an equivalent standard of living. *Id.*

The Commission also considered using a “discount from billed charges” method of determining payments to hospitals. A discount from billed charges is simply paying a percentage of the billed charges. However, the Commission rejected this method because:

it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective medical cost control and the statutory objective not to pay more than for similar treatment of an injured individual of an equivalent standard of living.

Id.

Like the supposedly (but not actually) “cost-based” methodology, a discount from billed charges approach also provided “no incentive to contain medical costs.” *Id.*

Even though the Texas Workers’ Compensation Commission rejected paying a percentage of billed charges as failing to provide effective medical cost control,

nevertheless, the *En Banc* Panel, and the SOAH ALJs that are deciding alleged stop-loss exception cases, are ordering payment of a percentage of billed charges.

III. Carrier Audit of Hospitals' Bills.

The *En Banc* Panel held that "Carriers' audit rights are not limited by § 134.401(c)(6)(A)(v) when the stop-loss reimbursement methodology applies. In such cases, carriers may audit in accordance with § 134.401(b)(2)(C). Joint Exhibit 2-1 at p. 15-16 (pages 12 and 13 of the Order). Subsection (b)(2)(C) provided "[a]ll charges submitted are subject to audit as described in Commission rules." Former rule 133.301(a) provided in part: "[t]he insurance carrier *shall* retrospectively review all complete medical bills and *pay for* or deny payment for *medical benefits in accordance with the Act*, rules, and the appropriate Division fee and treatment guidelines." 31 Tex. Reg. 1539 (2006) (emerg. rule 28 Tex. Admin. Code § 133.301) (adopted Mar. 10, 2006, expired May 1, 2006) (Tex. Dept. of Ins.), 25 Tex. Reg. 2128 (March 10, 2000), proposed 24 Tex. Reg. 10286 (November 19, 1999).

The use of the word "shall" in former rule 133.301(a) connotes a mandatory directive to pay according to the Texas Labor Code and the rules adopted there under. *Moseley v. Behringer*, 184 S.W.3d 829, 833 (Tex. App. - Fort Worth 2006, no pet.); *Hawkins v. Dallas County Hosp. Dist.*, 150 S.W.3d 535, 540-41 (Tex. App.- Austin 2004, no pet.); TEX. GOV'T CODE § 311.016(2). In other words, regardless of the reimbursement

methodology used, the statutory standards must be met. Any reimbursement contrary to the statutory standards is invalid.

As stated *supra*, former rule 133.304(i) required insurance carriers to make fair and reasonable reimbursements to hospitals for their services and treatments when there was no MAR. The *En Banc* Panel held that carriers are “allowed to audit” by rule 133.301(a) such “items as incorrect calculations, upcoding, unbundling, and duplicate billing.” Joint Exhibit 2-1 at p. 16 (page 13 of the Order). This holding limited the carriers’ audit rights contravening former rule 133.304(i) and the specific statutory provisions of Labor Code Section 413.011(d) cited above. As held in *State v. Public Util. Comm'n of Tex.*, 131 S.W.3d 314, 321 (Tex. App.- Austin 2004, pet. denied), an agency may not “contravene specific statutory language, run counter to the general objectives of the statute, or impose additional burdens, conditions, or restrictions in excess of or inconsistent with the relevant statutory provisions.”

The Labor Code “does not define ‘examination’ or ‘audit, so we may rely on definitions listed in commonly used dictionaries to discern the plain meaning of terms in the statute. See *Powell v. Stover*, 165 S.W.3d 322, 326 (Tex. 2005); *Texas Dep't of Protective & Regulatory Servs. v. Mega Child Care, Inc.*, 145 S.W.3d 170, 196 (Tex. 2004); *Sheshunoff v. Sheshunoff*, 172 S.W.3d 686, 695 n.8 (Tex. App - Austin 2005, pet. denied). An “examination” is “an inspection” or “analysis.” American Heritage Dictionary 456 (1973). An audit is a “formal examination of an individual's or organization's

accounting records, financial situation, or compliance with some other set of standards." Black's Law Dictionary 126 (7th ed. 1999). It may involve "an adjustment or correction of accounts." American Heritage Dictionary 86. After limiting carriers' audit rights, the *En Banc* Panel goes on to hold that "a hospital need only establish that total audited charges exceed the Stop-Loss Threshold of \$40,000 in order to apply the stop-loss reimbursement methodology under 28 TEX. ADMIN. CODE § 134.401(c)(6); there is no additional requirement for a hospital to establish separately that the services provided were unusually costly or extensive. Joint Exhibit 2-1 at p. 19 (page 16 of the Order).

Appellee, Texas Department of Insurance, Division of Workers' Compensation claims on page 2 of its Brief that "[t]here is a critical difference between 'billed' charges or 'a hospital's charges,' on the one hand, and 'audited charges,' on the other." As shown in the following three paragraphs, this is not the case. Two SOAH ALJs have disregarded this "distinction" between billed charges and audited charges.

In Joint Exhibit 3-1, the Decision and Order in SOAH Docket No. 453-05-9670 M4; *Rio Grande Hospital v. Texas Mutual Insurance Company*, ALJs Howard S. Seitzman, and Tommy L. Broyles made Findings of Fact 6 and 7. Findings of Fact 6 and 7 reference that other than auditing and paying under the per diem methodology, no other audit reductions were made. Texas Mutual's audit of the hospital's bill to per diem was based on its conclusion that the admission was not unusually extensive and costly, as required under the two prong test. Joint Exhibit 3-1 at p. 4 (page 3 of the Decision and Order).

ALJs Seitzman and Broyles did the exact same thing in SOAH Docket No. 453-05-5545.M4; *Spring Branch Medical Center v. Texas Mutual Insurance Company* even though Texas Mutual had audited the bill under the two prong test. Joint Exhibit 3-2. See also SOAH Docket No. 453-03-4132.M4; *Texas Mutual Insurance Company v. HCA Clear Lake Regional Medical Center* (Joint Exhibit 3-3), SOAH Docket No. 453-04-7714.M4; *Texas Mutual Insurance Company v. Spring Branch Medical Center* (Joint Exhibit 3-4), SOAH Docket No. 453-03-4132.M4; *Texas Mutual Insurance Company v. Clear Lake Regional Medical Center* (Joint Exhibit 3-5), and in SOAH Docket No. 453-05-4985.M4; *Spring Branch Medical Center v. Texas Mutual Insurance Company*. Joint Exhibit 3-6.

Even though the Texas Workers' Compensation Commission rejected paying a percentage of billed charges as failing to provide effective medical cost control, the *En Banc* Panel, and the two SOAH ALJs are ordering just this method of reimbursement. Judge Cooper ignored the Commission's expertise in this area when she held that payment of a percentage of billed charges complies with Texas Labor Code Section 413.011(d). CR 1344. Like the *En Banc* Panel, Judge Cooper denied the carriers' audit authority to provide fair and reasonable reimbursements to hospitals. CR 1345. This construction of 28 TEX. ADMIN. CODE § 134.401(c)(6) is invalid because it fails to provide for effective medical cost control, and conflicts with the Labor Code Subsection 413.011(d) restriction on payments 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.

IV. Payment of Hospitals' Charges.

The Texas Workers' Compensation Commission found that persons with an equivalent standard of living to injured workers covered by workers compensation insurance include Medicare patients. 22 TEX. REG. 6264, 6284 (July 4, 1997). Medicare pays hospitals per federal rules. 27 Tex. Reg. 11521, 11523 (December 6, 2002); 21 Tex. Reg. 8219, 8287 (August 30, 1996). As testified to at trial, "[f]ew patients today ever pay a hospital's full charges due to the prevalence of Medicare, Medicaid, HMOs and private insurers who pay discounted rates." RR 2-131-132. As found by the Commission when adopting the 1997 Guideline, "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 Tex. Reg. at 6297. (Emphasis added). Vista itself bragged that its "business model often results in increased amounts of reimbursement for the same or similar procedures, as compared to other healthcare providers." TMIC Exhibit 2 at 24 (Dnyacq fiscal 2006 SEC 10-k). Judge Cooper's holding that carriers are to pay seventy-five percent of audited charges contravenes Labor Code Section 413.011(d).

V. The 1997 Guideline Treated as an Entitlement to Payment Amount.

In response to Zenith Insurance Company's validity challenges to the 1997 Guideline, Appellee, Texas Department of Insurance, Division of Workers' Compensation

(Division) claims on page 13 of its Brief that the continued application of a decade old guideline that is not Medicare-based is not a concern based on the implication that guidelines are not really binding. In other words, the Division suggests it is not bound to award the amount provided by the fee guideline and, in fact, has the authority to award more or less reimbursement than the amount provided by the fee guideline. ICT agrees. However, the Division's argument is misleading at best because it applies the fee guideline as if it creates a binding entitlement, notwithstanding its citation to *Methodist Hosps. v. Texas Workers' Compensation Comm'n*, 874 S.W.2d 144, 149-50 (Tex. App. - Austin 1994, writ dismissed w.o.j.). The Division states in its brief that "fee guidelines *were never intended to be entitlements* or statements of *a maximum payment amount*." This statement is in direct contradiction to the Division's position in the *Patient Advocates* case.

In the *Patient Advocates* case, the Court rejected Advocates' argument that the guideline is not mandatory and that it simply provides a suggestive range of fees that the Commission considers fair and reasonable. Instead, the Court agreed with the Commission, upholding the guideline's imposition of mandatory caps on medical fees as complying with the Workers' Compensation Act:

In this case, Advocates complains that the Commission exceeded its statutory authority by establishing a mandatory ceiling on medical fees when the plain meaning and intent of the term "guideline" suggests a voluntary rather than a mandatory ceiling on medical fees. According to Advocates, the Guideline should do nothing more than provide a suggestive range of fees that the Commission considers to be fair and reasonable.

The Commission, on the other hand, insists that there is nothing in the Act that prohibits a rule that imposes a mandatory cap on medical fees. Indeed, the Commission points to its mandate of controlling medical costs as strong evidence that the Legislature implicitly delegated to it the authority to set a ceiling on medical costs. Our review of the entire structure of the Act leads us to the conclusion that the Commission has this delegated power by implication, if not expressly.

80 S.W.3d 66, 76 (Tex. App.—Austin, 2002).

Thus, the Division's assertion that the 1997 Guideline was never intended to be a statement of a *maximum payment amount* is 180 degrees from the position it took in the *Patient Advocates* case that guidelines impose a *mandatory cap* on medical fees.

The Division's assertion, for purposes of this case, that the 1997 Guideline was never intended to be a statement of a maximum payment amount is also directly contradicted by the plain language of each of the Division's fee guidelines which were adopted after the holding in *Methodist Hospitals*, and which state that the fee guidelines set forth the *maximum allowable reimbursement* ("MAR") for the services addressed by each guideline.²¹ Under the Division's rules, when a MAR is established for a particular

21. Medical Fee Guideline - "To determine the *maximum allowable reimbursements (MARs)* for professional services system participants shall apply the Medicare payment policies with the following minimal modifications:" 28 TEX. ADMIN. CODE § 134.202(c).

Dental Fee Guideline - "To determine the *maximum allowable reimbursements (MARs)*, the following apply:" 28 TEX. ADMIN. CODE § 134.303(c).

Inpatient Hospital Fee Guideline - "Standard Per Diem Amount (SPDA)-A standardized per diem amount established by the Commission as the *maximum reimbursement* for hospital services covered by this guideline." 28 TEX. ADMIN. CODE § 134.401(b)(1)(J).

Ambulatory Surgical Center Fee Guideline - "To determine the *maximum allowable reimbursement (MAR)* for a particular service, system participants shall apply the Medicare

medical treatment or service, the amount of reimbursement payable to a health care provider is the lesser of the provider's usual and customary charges or the MAR established in the applicable fee guideline.²²

The Division cites the *Methodist Hospitals* case as if it endorses this Court's holding that the 1997 Guideline is merely a "guideline," when it knows full well that is not how it is applying the 1997 Guideline or how SOAH is applying the 1997 Guideline. Whatever amount the guideline specifies, is the amount the Division requires the carrier to pay. All of the alleged stop-loss cases decided by the Division have been decided by application of the 1997 Guideline and the Division has not deviated from the 1997 Guideline amount, whether the *per diem* or the stop-loss exception. In his deposition, the Division's corporate representative and former head of the Medical Review Division testified as follows:

Q. Are you aware of any MRD decisions in which the agency has awarded a different amount than that provided by the fee guideline?

A. No, sir, I am not.²³

In an attempt to ameliorate its failure to comply with Labor Code Sections 413.011 and 413.012, the Division argues in its Brief that the 1997 Guideline does not create an entitlement. Yet, that is exactly how it is being applied by the Division and SOAH.

payment policies for these services and the Medicare ASC reimbursement amount multiplied by 213.3%." 28 TEX. ADMIN. CODE § 134.402(c).

22. 28 TEX. ADMIN. CODE §§ 134.202(d), 134.303(e), 134.401(b)(2)(A).

23. Joint Exhibit 7 at p. 79.

Meanwhile, the SOAH ALJs following the En Banc Panel's rulings have specifically rejected the argument that the 1997 Guideline is simply a guideline intended to provide guidance to the parties and agency in determining fair and reasonable reimbursement under the statutory standards. As a result, the SOAH ALJs will not consider whether the amount of the reimbursement made in a particular case complies with the statutory standards for reimbursement. Such SOAH ALJs simply award seventy-five (75%) percent of billed charges.²⁴ The SOAH ALJs have ignored this Court's holding in *Methodist Hospitals and Texas Workers' Comp. Comm'n v. E. Side Surgical Ctr*, 142 S.W.3d 541 (Tex. App. - Austin 2004, no pet.).

Because of these SOAH ALJs position, yet another declaratory judgment suit has been filed seeking a declaration that the 1997 Guideline is simply a guideline, which creates a presumption of "fair and reasonable" reimbursement that can be rebutted, rather than an automatic entitlement to the amount provided in the 1997 Guideline's stop-loss exception.²⁵ The suit argues that it is unlawful and improper for the SOAH ALJs to refuse to consider whether payment under the stop-loss exception in a particular case is consistent with the statutory standards for fair and reasonable reimbursement and to instead automatically apply the 1997 Guideline as creating a binding entitlement to the amount,

²⁴ See Joint Exhibits 3-1 – 3-6.

²⁵ *Texas Prop. & Cas. Ins. Guar. Ass'n v. Vista Community Med. Ctr.*, Cause No. D-1-GN-08-000263 (345th Dist. Ct., Travis Co., Tex.).

according to their interpretation, provided by the stop-loss exception.²⁶ This Court should take the opportunity to re-affirm its holding in the *Methodist Hospitals* and *East Side* cases by declaring that the 1997 Guideline does not create a binding entitlement to the amount provided by the stop-loss exception.

However, even if the SOAH ALJs following the En Banc Panel's rulings treated the 1997 Guideline as creating a rebuttable presumption and therefore, gave carriers an opportunity to show that reimbursement under the stop-loss exception is inconsistent with the statutory standards for fair and reasonable reimbursement in a particular case, that would still not excuse the Division's failure to ever update the 1997 Guideline or to adopt a Medicare-based guideline to be effective on March 1, 2008. The reason is because the carriers would still be required to overcome a presumption that would otherwise not exist.

CONCLUSION AND PRAYER

The Insurance Council of Texas joins Texas Mutual Insurance Company, Zenith Insurance Company, Liberty Mutual Insurance Company, and Zurich American Insurance Company in praying this Court reverse the trial court's holdings; declare that the stop-loss exception to the 1997 Guideline invalid due to the failure of the Division to adopt a Medicare based hospital fee guideline as well as update its hospital fee guideline every two

26. The SOAH ALJs following the En Banc Panel's rulings set fifteen (15) stop-loss exception cases for hearing on a single day. The reason is because the only remaining issues in most of these cases are the amount billed, the amount paid, and the attendant mathematical calculations. It would admittedly take longer to try each of these disputes if these ALJs required the hospitals to prove the medical necessity of and justification for their charges and allowed carriers to put on evidence that the stop-loss reimbursement amount is not consistent with the statutory standards for fair and reasonable reimbursement in a given case.

years; declare the stop-loss exception, as interpreted by the trial court, violates Texas Labor Code Section 413.011, and unconstitutionally delegates to hospitals the power to set their own reimbursements; and declare that insurance carriers have the right to audit hospitals' bills to fair and reasonable as provided by statute and agency rule. In the alternative, Insurance Council of Texas, prays this Court interpret the stop-loss exception to the 1997 Guideline as requiring a two prong test: (1) charges after audit exceed \$40,000.00, and (2) the admission involves unusually costly or unusually extensive services.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I have on this the 15th day of August, 2008, served a copy of the foregoing **Brief of Amicus Curiae Insurance Council of Texas** by certified mail, return receipt requested, and/or first class mail, and/or hand-delivery, and/or facsimile transmission, and/or overnight delivery to all parties through the following counsel:

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APPENDIX

Final Judgment Tab 1

Consolidated Order No. 4 Memorializing Prehearing Conference and Issuing Briefing
Outline Tab 2

Comments of Texas Mutual and ICT to the Proposed Repeal of the 1997 Guideline Tab 3

Comments of John D. Pringle to the Proposed Repeal of the 1997 Guideline Tab 4

TEX. LAB. CODE § 413.011 Tab 5

28 TEX. ADMIN. CODE § 133.301 Tab 6

28 Tex. Admin. Code §134.1 Tab 7

28 TEX. ADMIN. CODE §134.401 Tab 8

22 Tex. Reg. 6264 (July 4, 1997) Tab 9

25 Tex. Reg. 2126 (March 10, 2000) Tab 10