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

APPENDIX TO BRIEF OF AMICUS CURIAE

INSURANCE COUNCIL OF TEXAS

Respectfully submitted,

PRINGLE & GALLAGHER, L.L.P.
John D. Pringle
State Bar No. 16330300
Laurie S. Gallagher
State Bar No. 24000166
The Vaughn Building
807 Brazos, Suite 200
Austin, Texas 78701
(512) 472-8742
(512) 472-8745 (Facsimile)

ATTORNEYS FOR INSURANCE COUNCIL OF TEXAS

August 15, 2008

APPENDIX TO BRIEF OF AMICUS CURIAE
INSURANCE COUNCIL OF TEXAS

1

LM

NO. D-1-GN-06-000213

VISTA COMMUNITY MEDICAL CENTER, LLP d/b/a VISTA MEDICAL CENTER HOSPITAL, Plaintiff	§	IN THE DISTRICT COURT
Vs.	§	OF TRAVIS COUNTY, TEXAS
TEXAS MUTUAL INSURANCE COMPANY and THE DIVISION OF WORKER'S COMPENSATION, Defendants	§	353RD JUDICIAL DISTRICT

MD

ZENITH INSURANCE COMPANY Intervenor-Counterclaimant	§	IN THE DISTRICT COURT
Vs.	§	
TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION f/k/a TEXAS WORKERS' COMPENSATION COMMISSION, ALBERT BETTS, IN HIS OFFICAL CAPACITY AS COMMISSIONER OF THE DIVISION, the STATE OFFICE OF ADMINISTRATIVE HEARINGS, and SHEILA BAILEY TAYLOR, IN HER OFFICIAL CAPACITY AS CHIEF ADMINISTRATIVE LAW JUDGE	§	OF TRAVIS COUNTY, TEXAS
	§	353RD JUDICIAL DISTRICT

FINAL JUDGMENT

On September 4-5, 2007 came on to be heard the above entitled and numbered cause. The following parties and their counsel appeared and announced ready for trial on the merits: Vista Community Medical Center d/b/a Vista Medical Center Hospital (Plaintiff), Christus Health Gulf Coast (Intervenor-Plaintiff), Texas Mutual Insurance Company (Defendant-

Counterclaimant), Texas Department of Insurance, Division of Workers' Compensation (Defendant), Zenith Insurance Company, Liberty Mutual Insurance Company, Zurich American Insurance Company, the State Office of Risk Management (Intervenors-Counterplaintiffs), and the State Office of Administrative Hearings (Counter-Defendant).

No jury was demanded.

The Court proceeded to hear, weigh and consider the evidence and to receive and consider post trial briefs, and on October 16, 2007, the Court heard the parties' oral arguments. After hearing and considering the evidence, briefs and arguments, the Court has determined that a judgment should be entered as follows:

IT IS ORDERED, ADJUGED AND DECREED as follows:

1. The Court declares that the stop-loss reimbursement methodology of the Acute Care Inpatient Hospital Fee Guideline found at 28 Texas Administrative Code § 134.401(c)(6) requires only that a provider prove that its total audited charges exceed $40,000 in order for the stop-loss reimbursement methodology to apply; there is no additional requirement that a provider prove that the admission was unusually costly, or unusually extensive in order for the stop-loss reimbursement methodology to apply.

2. The Court declares that the Staff Report that was admitted into evidence as Vista Exhibit 9 and Joint Exhibit 4 is an administrative rule as defined in Tex. Gov't Code § 2001.003(6) and is invalid and voidable because it was not adopted in substantial compliance with Tex. Gov't Code § 2001.0225 through Tex. Gov't Code § 2001.034.

3. Instead of remanding the rule to the Division under Tex. Gov't Code § 2001.040 to allow a reasonable time for the Division to either revise or readopt the rule through established procedures, the Court finds good cause to immediately invalidate the Staff Report because the

Court holds that, absent the addition of objective criteria, the phrases "unusually costly" and "unusually extensive" as used by the Division are so vague and uncertain that their use in determining whether the stop-loss reimbursement methodology applies would be arbitrary.

4. The Court declares that when determining whether payment is due under 28 Tex. Admin. Code § 134.401(c)(6), a carrier is authorized to audit all hospital charges in accordance with applicable Division retrospective review rules, and is not limited to auditing for the deductions as described in 28 Tex. Admin. Code § 134.401(c)(6)(A)(v).

5. The Court declares that under 28 Tex. Admin. Code § 134.401(c)(6), a carrier is not authorized to reduce the provider's usual and customary charges for implantables, orthotics and prosthetics to cost plus 10% in determining whether the stop-loss reimbursement methodology applies or for reimbursement purposes.

IT IS FURTHER ORDERED that each party and intervenor shall bear its own costs of court, attorneys' fees and other expenses in this action.

IT IS FURTHER ORDERED THAT any relief sought or requested by any party which is not specifically granted by this judgment is denied. This judgment finally disposes of all parties and claims and is appealable. This judgment is intended to be a Final Judgment.

SIGNED on this 6 day of November, 2007.

Margaret A. Cooper
MARGARET A. COOPER
Judge, 353rd Judicial District Court

APPROVED AS TO FORM:

David F. Bragg
State Bar No. 02857300
Law Offices of David F. Bragg, P.C.
823 Congress Avenue, Suite 1100
Austin, Texas 78701
Telephone: 512.474.5573
Telecopier: 512.474.5580

Eric C. Carter
State Bar No. 03904500
The Carter Law Firm
807 Brazos Street, Suite 901
Austin, Texas 78701
(512) 494-8900
FAX: (512) 494-8901
Attorneys for Vista Medical Center Hospital

Nicholas Canaday, III
State Bar No. 00790072
Assistant Attorney General
Administrative Law Division
P. O. Box 12548, Capitol Station
Austin, Texas 78711-2548
FAX: (512) 474-1062
Attorneys for the Texas Department of Insurance, Division of Workers' Compensation

P. M. Schenkkan
State Bar No. 17741500
Graves, Dougherty, Hearon & Moody, P.C.
P. O. Box 98
Austin, Texas 78767-0098
FAX: (512) 480-5840
Attorneys for Texas Mutual Insurance Company

APPROVED AS TO FORM:

David F. Bragg
State Bar No. 02857300
Law Offices of David F. Bragg, P.C.
823 Congress Avenue, Suite 1100
Austin, Texas 78701
Telephone: 512.474.5573
Telecopier: 512.474.5580

Eric C. Carter
State Bar No. 03904500
The Carter Law Firm
807 Brazos Street, Suite 901
Austin, Texas 78701
(512) 494-8900
FAX: (512) 494-8901
Attorneys for Vista Medical Center Hospital

Nicholas Canaday, III
State Bar No. 00790072
Assistant Attorney General
Administrative Law Division
P. O. Box 12548, Capitol Station
Austin, Texas 78711-2548
FAX: (512) 474-1062
Attorneys for the Texas Department of Insurance, Division of Workers' Compensation

P. M. Schenkkan
State Bar No. 17741500
Graves, Dougherty, Hearon & Moody, P.C.
P. O. Box 98
Austin, Texas 78767-0098
FAX: (512) 480-5840
Attorneys for Texas Mutual Insurance Company

James M. Loughlin
State Bar No. 00795489
Stone Loughlin & Swanson, LLP
P. O. Box 30111
Austin, Texas 78755
(512) 343-1300
FAX: (512) 343-1385

J. Stephen Ravel
State Bar No. 16584975
Kelly Hart & Hallman, LLP
301 Congress Avenue, Suite 2000
Austin, Texas 78701
(512) 495-6400
FAX: (512) 495-6401
Attorneys for Zenith Insurance Company

Kevin Molina
State Bar No.
Assistant Attorney General
Tort Litigation Division
P. O. Box 12548
Austin, Texas 78711
(512) 475-0140
FAX: (512) 463-2224
Attorneys for State Office of Risk Management

James M. Loughlin
State Bar No. 00795489
Stone Loughlin & Swanson, LLP
P. O. Box 30111
Austin, Texas 78755
(512) 343-1300
FAX: (512) 343-1385

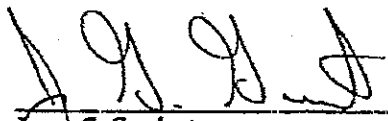
J. Stephen Ravel
State Bar No. 16584975
Kelly Hart & Hallman, LLP
301 Congress Avenue, Suite 2000
Austin, Texas 78701
(512) 495-6400
FAX: (512) 495-6401
Attorneys for Zenith Insurance Company

Kevin Molina
State Bar No.
Assistant Attorney General
Tort Litigation Division
P. O. Box 12548
Austin, Texas 78711
(512) 475-0140
FAX: (512) 463-2224
Attorneys for State Office of Risk Management

James M. Loughlin
State Bar No. 00795489
Stone Loughlin & Swanson, LLP
P. O. Box 30111
Austin, Texas 78755
(512) 343-1300
FAX: (512) 343-1385

J. Stephen Ravel
State Bar No. 16584975
Kelly Hart & Hallman, LLP
301 Congress Avenue, Suite 2000
Austin, Texas 78701
(512) 495-6400
FAX: (512) 495-6401
Attorneys for Zenith Insurance Company

Kevin Molina
State Bar No. 24041505
Assistant Attorney General
Tort Litigation Division
P. O. Box 12548
Austin, Texas 78711
(512) 475-0140
FAX: (512) 463-2224
Attorneys for State Office of Risk Management



James G. Gumbert
State Bar No. 08618450
Hollaway & Gumbert
3701 Kirby Drive, Suite 1288
Houston, Texas 77098
(713) 942-7900
FAX: (713) 942-8530
Attorneys for Christus Health Gulf Coast

Robert F. Josey
State Bar No. 00796853
Henna & Plaut, LLP
The Littlefield Building
106 East Sixth Street, Suite 600
Austin, Texas 78701
(512) 472-7700
FAX: (512) 472-0205
Attorneys for Liberty Mutual Insurance Company

Paul L. Kelley
State Bar No. 00796867
Law Offices of Paul Kelley
9600 Escarpment Blvd., Suite 745-74
Austin, Texas 78749
(512) 691-9501
FAX: (512) 691-9509
Attorney for Zurich American Insurance Company

James G. Gumbert
State Bar No. 08618450
Hollaway & Gumbert
3701 Kirby Drive, Suite 1288
Houston, Texas 77098
(713) 942-7900
FAX: (713) 942-8530
Attorneys for Christus Health Gulf Coast

Robert E. Josey
State Bar No. 00796853
Hanna & Plaut, LLP
The Littlefield Building
106 East Sixth Street, Suite 600
Austin, Texas 78701
(512) 472-7700
FAX: (512) 472-0205
Attorneys for Liberty Mutual Insurance Company

Paul L. Kelley
State Bar No. 00796867
Law Offices of Paul Kelley
9600 Escarpment Blvd., Suite 745-74
Austin, Texas 78749
(512) 691-9501
FAX: (512) 691-9509
Attorney for Zurich American Insurance Company

James G. Gumbert
State Bar No. 08618450
Hollaway & Gumbert
3701 Kirby Drive, Suite 1288
Houston, Texas 77098
(713) 942-7900
FAX: (713) 942-8530
Attorneys for Christus Health Gulf Coast

Robert F. Josey
State Bar No. 00796853
Hanna & Plaut, LLP
The Littlefield Building
106 East Sixth Street, Suite 600
Austin, Texas 78701
(512) 472-7700
FAX: (512) 472-0205
Attorneys for Liberty Mutual Insurance Company

Paul L. Kelley
State Bar No. 00796867
Law Offices of Paul Kelley
9600 Escarpment Blvd., Suite 745-74
Austin, Texas 78749
(512) 691-9501
FAX: (512) 691-9509
Attorney for Zurich American Insurance Company

2

10110-597P

STOP-LOSS LEGAL ISSUES CONSOLIDATED DOCKET
SOAH DOCKET NO. 453-03-1487.M4 (LEAD DOCKET)
(TWCC MR NO. M4-02-3850-01)

HARTFORD CASUALTY INSURANCE COMPANY, Petitioner	§	BEFORE THE STATE OFFICE
V.	§	OF
VISTA HEALTHCARE, INC., Respondent	§	ADMINISTRATIVE HEARINGS

CONSOLIDATED ORDER NO. 4 MEMORIALIZING PREHEARING CONFERENCE AND ISSUING BRIEFING OUTLINE

At 9:00 a.m. on June 28, 2006, the En Banc Panel (Panel) convened a prehearing conference to consider the request of certain parties to allow the introduction of evidence into these proceedings and other preliminary issues raised by the parties. The prehearing conference adjourned at 12:45 p.m.

A. After hearing the arguments of the parties and considering their pleadings, the Panel makes the following decisions:

1. The briefing outline attached as Appendix A is the briefing outline to be followed by the parties.

2. A new briefing schedule is set forth in Attachment B to this Order. Parties may submit briefs individually or jointly. The initial briefs will be limited to 50 pages, exclusive of the table of contents, rule appendices and case appendices. Reply briefs will be limited to 25 pages, exclusive of the table of contents, rule appendices and case appendices. All filings shall comply with the requirements of Consolidated Order No. 1. Failure to comply with the filing requirements may result in the SOAH docketing office rejecting the filing.

3. The parties may proceed with supplementing the depositions of David Martinez and Allen C. McDonald, Jr. The Martinez and McDonald depositions are admitted conditioned upon submission of the depositions, as supplemented, by 5:00 p.m. on August 22, 2006, and subject to objections filed by that date. All other discovery remains **ABATED**.

EXHIBIT
tabbies
"9"

B The following tenders of evidence are denied:

1. Transcript of Hearing Regarding Threshold Legal Issues in Vista Consolidated Docket (ALJ Ramos, May 6, 2005–excerpts regarding testimony of Ron T. Luke, J.D., Ph.D., and Nicholas Tsoumas, M.D.

2. Video excerpts from a May 7, 2004 surgery performed by Nicholas Tsoumas, M.D. and his curriculum vitae.

3. The October 11, 2004 deposition of Jim E. Bryant, Jr., R.N.

4. The February 25, 2005 deposition of Janet Cheng.

5. The February 25, 2005 deposition of Jean Wincher.

6. The April 12, 2005 Report by Research & Planning Consultants, L.P.

C The Panel officially notices for the purpose of admitting into evidence:

1. All written decisions of the Texas Workers' Compensation Commission (Commission)[1] Medical Review Division resolving fee disputes between parties as to the application, if any, of the Stop-Loss exception to the Acute Care Hospital Fee Guideline (ACHFG)

2. Texas Register: 16 Tex. Reg. 3569 (1991) (emerg. rule 28 TEX. ADMIN. CODE § 134.400); 16 Tex. Reg. 3868 (1991) (withdrawal of emergency effectiveness of rule 28 TEX. ADMIN. CODE § 134.400); 17 Tex. Reg. 2246 (1992) (prop. new rule 28 TEX. ADMIN. CODE § 134.400); 17 Tex. Reg. 4949 (1992) (adopted 28 TEX. ADMIN. CODE § 134.400); 21 Tex. Reg. 6939 (1996) (prop. repeal of 28 TEX. ADMIN. CODE § 134.400 and prop. new 28 TEX. ADMIN. CODE § 134.401); 22 Tex. Reg. 1309 (1997) (withdraw prop. repeal of 28 TEX. ADMIN. CODE § 134.400 and prop. adoption of 28 TEX. ADMIN. CODE § 134.401); 22 Tex. Reg. 1579 (1997) (prop. new 28 TEX. ADMIN. CODE § 134.401 and prop. repeal of 28 TEX. ADMIN. CODE § 134.400); and 22 Tex. Reg. 6264 (1997) (adoption of 28 TEX. ADMIN. CODE § 134.401 and the repeal of 28 TEX. ADMIN. CODE § 134.400).

3. SOAH Decision and Orders: 453-97-0625 (1998 - ALJ C. Hayes); 453-00-2092 (2001 - ALJ G. Cunningham); 453-01-1612 (2001 - ALJ G. Cunningham); 453-02-1614 (2002 - ALJ S. Marshall); 453-03-0910 (2003 - ALJ K. Sullivan); 453-03-1233 (2003 - ALJ T. Walston); 453-03-1626 (2003- ALJ W. Harvel); 453-03-1628 (2003 -

[1] Effective September 1, 2005, the Texas Workers' Compensation Commission became the Texas Department of Insurance, Division of Workers' Compensation (collectively Commission)

ALJ S. Rivas); 453-03-3120 (2003 - ALJ H. Seitzman); 453-03-3581 (2004 - ALJ B. Zukauckas); 453-04-3600 (2004 - ALJ C. Church); 453-04-4223 (2004 - ALJ H. Card); 453-04-4338 (2004 - ALJ T. Walston); 453-04-4455 (2004 - ALJ G. Elkins); 453-04-5367 (2005 - ALJ T. Walston); and 453-04-8285 (2005 - ALJ B. Zukauckas).

4. All opinions of the district and appellate courts of the state addressing the ACHFG and the application, if any, of the Stop-Loss exception.

5. The rules of the Commission as promulgated in the Texas Administrative Code.

6. The video excerpts from the Commission's public meetings of January 20, 2005 and February 17, 2005.

All relief not expressly granted herein is **DENIED**.

SO ORDERED.

SIGNED July 7, 2006.

Catherine C. Egan

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX A
REVISED STOP-LOSS EN BANC PANEL ISSUES BRIEFING OUTLINE

I. Eligible Items

ISSUE 1: How is the $40,000 Stop-Loss Threshold calculated? Are all eligible items included in the calculation of the $40,000 Stop-Loss Threshold or are items listed in 28 TAC § 134.401(c)(4) excluded in their entirety from the calculation? If included, how are the dollar amounts of 28 TAC § 134.401(c)(4) items calculated?

II. Reimbursement Rate

ISSUE 2: If an admission is eligible for Stop-Loss payment, is reimbursement at 75%, or are the items listed in 28 TAC § 134.401(c)(4) reimbursed other than at 75% of eligible amounts? If reimbursement for 28 TAC § 134.401(c)(4) is not at 75% of eligible amounts, how is reimbursement calculated?

III. Audit

ISSUE 3A: If a Carrier fails to audit the Hospital's charges in the manner required by the Commission's audit rules, may it subsequently challenge the hospital's charges?

ISSUE 3B: Is a carrier's audit limited to the scope of 28 TAC § 134.401(c)(6)(A)(v) or may it audit as per 28 TAC § 134.401(b)(2)(C)?

IV. Effect of 28 TAC § 134.401(c)(6)

ISSUE 4: If the total eligible amounts are in excess of $40,000, does that by itself establish eligibility for applying 28 TAC § 134.401(c)(6) and thereby satisfy the unusually costly/ unusually extensive language in the rule? Or, is there an additional requirement that any or all of the services also be unusually costly and unusually extensive? If the latter, must each service be unusually costly and unusually extensive or does the rule require that only one service be unusually costly or extensive?

V. Staff Report

ISSUE 5: What is the effect of the February 17, 2005 Staff Report?

ISSUE 5A(1): Is the February 17, 2005 Staff Report consistent with 28 TAC § 134.401(c)(6) (the Stop-Loss Rule)? If the February 17, 2005 Staff Report is not consistent with the Commission's Stop-Loss Rule, what is the effect of the February 17, 2005 Staff Report?

ISSUE 5A(2): Is the February 17, 2005 Staff Report consistent with the Commission's interpretation of its Stop-Loss Rule, as set forth in, but not limited to, 21 Tex. Reg. 6939-6945 (July 26, 1996); 22 Tex. Reg. 1579-1596 (February 11, 1997); and 22 Tex. Reg. 6264-6308 (July 4, 1997) and the Commission's written decisions issued by its Medical Review Division? If the February 17, 2005 Staff Report is not consistent with the Commission's interpretation of its Stop-Loss Rule, what is the effect of the February 17, 2005 Staff Report?

ATTACHMENT B
PROPOSED SCHEDULE

DEADLINE ITEM	DATE
Parties' Comments to Schedule	Noon on Friday, July 14, 2006.
Initial Briefs to be Filed at SOAH and Received by Parties	Friday, October 6, 2006, by 5:00 p.m.
Reply Briefs to be Filed at SOAH and Received by Parties	Friday, October 20, 2006, by 5:00 p.m.
Oral Argument Before En Banc Panel	Friday, November 3, 2006, at 10:00 a.m.

3

Texas Mutual Insurance Company's Comments on Proposed Repeal of the 1997 Hospital Fee Guideline – 28 TEX. ADMIN. CODE § 134.401

Explain the Reasons for and Effect of Repeal of § 134.401 More Fully and Specifically

Texas Mutual urges the Division in its order of repeal to:

(1) explain the reasons for repeal in more detail than in the notice of proposed repeal, and

(2) explain the effect of repeal on pending fee disputes more specifically.

Explaining its reasons and the effect of repeal more fully will help the Division put the stop-loss exception debacle behind the Division, the hospitals, the carriers, and the courts.

If the Division fails to explain the reasons for and effect of repeal more fully, the Division will invite additional litigation.

Texas Mutual urges the Division to incorporate the substance of the following explanations into its final order of repeal.

Reasons for Repeal of the 1997 Hospital Fee Rule:

The Division's notice of proposed repeal states that: "Section 134.401 no longer meets the needs of the workers' compensation system. Since section 134.401 will no longer be needed after March 1, 2008, the Division proposes the repeal of section 134.401." 33 Tex. Reg. 1487 (Feb. 22, 2008).

1. The Division should more fully explain how repeal of the 1997 hospital fee rule is authorized or required by the Labor Code.

Repeal of a rule is rulemaking. In rulemaking, a Texas agency is required to supply a reasoned justification that must include "a concise restatement of the particular statutory provisions under which the rule is adopted and of how the agency interprets the provisions as authorizing or requiring the rule." TEX. GOV'T CODE § 2001.033(a)(2). The Division should more fully explain how repeal of the 1997 hospital fee rule is authorized or required by the Labor Code. Several reasons the Division can properly use in its explanation follow.

The 1997 rule is not Medicare-based – Effective as of 2002, Labor Code § 413.011 has required that Texas workers' compensation healthcare fee rules follow standardized Medicare reimbursement methodologies, models and relative weights and values. The 1997 hospital fee rule does not in any way track Medicare reimbursement methodologies, models and relative values for hospital inpatient services.

The 1997 hospital inpatient fee rule's standard payment methodology is per diem, with three levels for medical admissions, surgical admissions, and ICU/CCU, set in 1997. Medicare's

hospital inpatient reimbursement methodology provides cost-based reimbursement for each of numerous "diagnostic-related groups" of procedures, and the relative values of different procedures are determined using extremely detailed and current full cost information.

The 1997 hospital fee rule's "outlier" case payment method is the stop-loss exception. It does not tie outlier payments to hospital costs in outlier cases. Medicare's outlier payment method does tie outlier payments to outlier costs.

For admissions occurring on or after March 1, 2008, the Division adopted a new rule, 28 TEX. ADMIN. CODE § 134.403, which does comply with the Medicare-based reimbursement methodologies and relative value requirements of Labor Code § 413.011. But this new rule does nothing to cure the failure to have a Medicare-based rule in effect for admissions since 2002 and before March 1, 2008. Division data indicate that there are more than 1400 pending fee disputes concerning such admissions.

The 1997 hospital fee rule does not achieve effective medical cost control – The agency must also supply a reasoned justification for a rule, including a repeal, that states the "factual basis for the rule as adopted which demonstrates a rational connection between the factual basis for the rule and the rule as adopted," and "demonstrates in a relatively clear and logical fashion that the rule as adopted is a reasonable means to a legitimate objective" under the controlling statute. TEX. GOV'T CODE §§ 2001.033(a)(1)(B) and 2001.035(c). To ensure against a challenge to the repeal, the Division should more fully explain the ties between the facts and the statutory objectives of healthcare fee rules. Several explanations the Division can properly use follow.

Labor Code § 413.011 requires that Texas workers' compensation healthcare fee rules ensure effective medical cost control. Since at least 2005 the Division has recognized that the stop-loss exception, if it only requires total audited charges exceeding $40,000, is not a reasonable means to this statutory objective. On February 17, 2005, the Division released and implemented its Staff Report on "Agency Interpretation and Application of the Hospital Stop-Loss Reimbursement Method (Rule 134.401)."

The Staff Report noted that the stop-loss exception was from the beginning intended "to be used for 'unusually costly services' in admissions that involve 'unusually extensive services,'" and that it set a *threshold* of $40,000 in total audited charges.

The Staff Report recognized that at least as early as 2004 the $40,000 threshold no longer achieved effective medical cost control. "When the Commission initially adopted this rule, approximately 3% of workers' compensation hospitals stays met the threshold of $40,000. The charges associated with these hospital stays represented 17% of all billed hospital inpatient charges (excluding trauma cases). These few hospital stays were presumed to represent unusually extensive services. In reviewing the data for 2004, more than 28% of hospital stays met this threshold, representing more than 65% of all billed charges (excluding trauma cases). This large percentage increase indicates that a hospital charge of $40,000 or more is no longer, by itself, a good indicator that a hospital stay involves unusually extensive services."

The notice of proposed repeal alludes to these facts but does not finish the story, in two important ways.

First, $40,000 does not limit payment at 75% of total audited charges to unusually extensive services because hospitals set their own charges, unregulated. If there is no other limit than charges above $40,000, the stop-loss exception allows hospitals to require that they be paid more simply by the hospital charging more.

That does not achieve effective medical cost control. Indeed, it delegates the Division's government function of setting hospital payments to the hospitals themselves. Division data indicate that the amount in controversy (claimed by hospitals at 75% of charges in matters in which charges exceeded $40,000, less amounts paid at per diem plus carve-outs) in the more than 1400 pending fee disputes exceeds $70 million.

Second, the Division in the Staff Report dealt with the failure of the $40,000 total audited charge threshold to achieve medical cost control by adopting the interpretation that the 1997 fee rule authorized and required the Division to "determine whether or not the hospital stay involved unusually extensive services on a case-by-case basis." Vista challenged this interpretation. The Hon. Margaret Cooper ruled for Vista, and the Division has elected not to appeal.

Repeal of the 1997 hospital fee rule is therefore a reasonable, indeed required, means to address the statutory objective of effective medical cost control for all pre-March 1, 2008 admissions.

Effect of Repeal of the 1997 Hospital Fee Rule:

The Division's notice of proposed repeal states that: "Section 134.401 no longer meets the needs of the workers' compensation system. Since section 134.401 will no longer be needed after March 1, 2008, the Division proposes the repeal of section 134.401." 33 Tex. Reg. 1487 (Feb. 22, 2008). The Division clearly and understandably seeks to put the stop-loss exception debacle behind the Texas workers' compensation system, and intends repeal of the 1997 hospital fee rule for that purpose. The Division should more fully explain the effect of the repeal to avoid additional litigation and encourage settlements.

The Division's default rule will control pending cases – After the repeal of § 134.401, for admissions occurring before March 1, 2008 for which reimbursement has been timely disputed and the dispute has not been finally and non-appealably resolved, there will be no applicable fee guideline setting a specific maximum allowable reimbursement.

In such a case, Division rule § 134.1 applies. *All Saints Hospital System v. Texas Workers' Compensation Commission*, 125 S.W.3d 96 Tex. App – Austin 2003, pet. denied).

Division rule § 134.1 subsections (c)(3)-(d) require that in the absence of an applicable fee guideline setting a specific MAR, fair and reasonable reimbursement must be "consistent with the criteria of Labor Code § 413.011."

Specifying the effect of repeal will discourage additional wasteful litigation – Vista and perhaps other hospitals may challenge the application of the default rule to the admissions before March 1, 2008 for which fee disputes are pending. The Division can and should reduce this litigation risk by specifying that the default rule controls.

The United States Supreme Court has held that " a court is to apply the law in effect at the time it renders its decision, unless doing so would result in manifest injustice or there is statutory direction or legislative history to the contrary." *Bradley v. School Board of Richmond*, 94 S.Ct. 2006, 2016 (1974).

There is nothing manifestly unjust about a hospital being paid a fee that is fair and reasonable under the statutory standards, as Division rule § 134.1 subsections (c)(3)-(d) require. The statutory standards define what is a fair and reasonable fee.

In the absence of clarification of the effect of the repeal, Vista and any allies may argue that, despite the repeal of the 1997 fee rule, there is direction or intent by the Division that the 1997 fee rule continue to control all admissions before March 1, 2008, and that Division rule § 134.1 subsections (c)(3)-(d) would not control still-pending fee disputes over admissions occurring before March 1, 2008.

The Division should dispose of this risk by including the following language in its repeal of 28 TEX. ADMIN CODE § 134.401:

"After the repeal of 28 Tex. Admin. Code §134.401, for inpatient hospital admissions occurring before March 1, 2008 for which medical fee disputes are timely filed and pending at the Medical Review Division, at the State Office of Administrative Hearings, or in court, determinations whether additional payment is due will be governed by Division rule 134.1(c)(3)-(d), which makes applicable the Labor Code section 413.011 statutory reimbursement standards."

Clarifying that repeal applies to pending cases is necessary to moot the SLX litigation – Repeal of the 1997 hospital inpatient fee rule, resulting in application of the statutory standards pursuant to Division rule § 134.1(c)(3)-(d), will moot all pending stop loss exception litigation. Failure to make the repeal result in the application of Division rule § 134.1(c)(3)-(d) would mean that the litigation will continue for years more, and then end in the same way – application of Division rule § 134.1(c)(3)-(d).

After the Division's decision not to appeal, the core of the pending litigation is about the validity of the 1997 fee rule's stop-loss exception assuming that exception only requires hospital charges exceeding $40,000. Repeal making Division rule § 134.1(c)(3)-(d) control all fee disputes on pre-March 1, 2008 admissions moots that litigation.

If, however, Vista challenges the effectiveness of repeal to make Division rule § 134.1(c)(3)-(d) control all fee disputes on pre-March 1, 2008 admissions, and if Vista prevails, then it will be necessary for the courts to determine the validity of a rule that only requires that total audited charges exceed $40,000 and does not regulate charges. It will be at least 2009 and perhaps 2010

before the Third Court of Appeals issues its decision, and petitions for review by the Texas Supreme Court may postpone a final decision until 2011 and 2012.

Repeal specifying that Division rule § 134.1(c)(3)-(d) controls will encourage SLX settlements – If the Division specifies in repealing the 1997 hospital fee rule that Division rule § 134.1(c)(3)-(d) controls fee disputes over pre-March 1, 2008 admissions, and moots the pending litigation over the 1997 fee rule's exception, this will encourage prompt settlements of what is "fair and reasonable" payment for such disputes, at or near the Division's new Medicare-based fee rule fees.

This is the best hope the Division has to encourage settlements of the more than 1400 stop-loss exception fee disputes its data show as pending, at levels that the Division's new Medicare-based fee rule indicates are fair and reasonable.

John D. Pringle

From: Steve Nichols [snichols@insurancecouncil.org]
Sent: Monday, March 24, 2008 3:53 PM
To: RuleComments@tdi.state.tx.us
Cc: Albert Betts@tdi.state.tx.us; Norma.Garcia@tdi.state.tx.us; Matthew.Zurek@tdi state.tx.us; Mary.Landrum@tdi.state.tx.us; Rick Gentry; johndpringle@sbcglobal.net; Geoff Billings
Subject: Insurance Council of Texas Supplemental Comments on Proposed Repeal of the 1997 Hospital Fee Guideline - 28 TEX. ADMIN. CODE § 134.401
Importance: High

Commissioner Betts:

Please accept the following comments as ICT's supplemental comments on the proposed repeal of the Acute Care Inpatient Hospital Fee Guideline,

28 TEX. ADMIN. CODE § 134.401.

I would welcome an opportunity to meet with you to discuss the attached comments prior to action being taken on the proposed rule repeal. A formal

request for the meeting is included in the attached comments.

Respectfully,

Steven W. Nichols

Manager, Workers' Compensation Services

Insurance Council of Texas

Tel. No.: (512) 326-7618 or 444-9611

Fax. No.: (512) 444-0734

E-mail: snichols@insurancecouncil.org

Insurance Council of Texas Supplemental Comments on Proposed

Repeal of the 1997 Hospital Fee Guideline – 28 Tex. Admin. Code § 134.401

Explain the Reasons for and Effect of Repeal of § 134.401 More Fully and Specifically

The Insurance Council of Texas (ICT) urges Commissioner Betts in his order of repeal to:

(1) explain the reasons for repeal in more detail than in the notice of proposed repeal, and

(2) explain the effect of repeal on pending fee disputes more specifically.

Explaining its reasons and the effect of repeal more fully will help the Division of Workers' Compensation (DWC) put the stop-loss exception issue and disputes behind the DWC, the hospitals, the carriers, and the courts.

If the DWC fails to explain the reasons for and effect of repeal more fully, the DWC will invite additional litigation.

ICT urges the DWC to incorporate the substance of the following explanations into its final order of repeal.

Reasons for Repeal of the 1997 Hospital Fee Rule:

The DWC's notice of proposed repeal states that: "Section 134.401 no longer meets the needs of the workers' compensation system. Since section 134.401 will no longer be needed after March 1, 2008, the DWC proposes the repeal of section 134.401." 33 Tex. Reg. 1487 (Feb. 22, 2008).

1. The DWC should more fully explain how repeal of the 1997 hospital fee rule is authorized or required by the Labor Code.

Repeal of a rule is rulemaking. In rulemaking, a Texas agency is required to supply a reasoned justification that must include "a concise restatement of the particular statutory provisions under which the rule is adopted and of how the agency interprets the provisions as authorizing or requiring the rule." Tex. Gov't Code § 2001.033(a)(2). The DWC should more fully explain how repeal of the 1997 hospital fee rule is authorized or required by the Labor Code. Several reasons the DWC can properly use in its explanation follow.

The 1997 rule is not Medicare-based – Effective as of 2002, Labor Code § 413.011 has required that Texas workers' compensation healthcare fee rules follow standardized Medicare reimbursement methodologies, models and relative weights and values. The 1997 hospital fee rule does not in any way track Medicare reimbursement methodologies, models and relative values for hospital inpatient services.

The 1997 hospital inpatient fee rule's standard payment methodology is per diem, with three levels for medical admissions, surgical admissions, and ICU/CCU, set in 1997. Medicare's hospital inpatient reimbursement methodology provides cost-based reimbursement for each of numerous "diagnostic-related groups" of procedures, and the relative values of different procedures are determined using extremely detailed and current full cost information.

The 1997 hospital fee rule's "outlier" case payment method is the stop-loss exception. It does not tie outlier payments to hospital costs in outlier cases. Medicare's outlier payment method does tie outlier payments to outlier costs.

For admissions occurring on or after March 1, 2008, the DWC adopted a new rule, 28 Tex. Admin. Code § 134.403, which does comply with the Medicare-based reimbursement methodologies and relative value requirements of Labor Code § 413.011. But this new rule does nothing to cure the failure to have a Medicare-based rule in effect for admissions since 2002 and before March 1, 2008. DWC data indicate that there are more than 1400 pending fee disputes concerning such admissions.

The 1997 hospital fee rule does not achieve effective medical cost control – The agency must also supply a reasoned justification for a rule, including a repeal, that states the "factual basis for the rule as adopted which demonstrates a rational connection between the factual basis for the rule and the rule as adopted," and "demonstrates in a relatively clear and logical fashion that the rule as adopted is a reasonable means to a legitimate objective" under the controlling statute. Tex. Gov't Code §§ 2001.033(a)(1)(B) and 2001.035(c). To

ensure against a challenge to the repeal, the DWC should more fully explain the ties between the facts and the statutory objectives of healthcare fee rules. Several explanations the DWC can properly use follow.

Labor Code § 413.011 requires that Texas workers' compensation healthcare fee rules ensure effective medical cost control. Since at least 2005 the DWC has recognized that the stop-loss exception, if it only requires total audited charges exceeding $40,000, is not a reasonable means to this statutory objective. On February 17, 2005, the DWC released and implemented its Staff Report on "Agency Interpretation and Application of the Hospital Stop-Loss Reimbursement Method (Rule 134.401)."

The Staff Report noted that the stop-loss exception was from the beginning intended "to be used for 'unusually costly services' in admissions that involve 'unusually extensive services,'" and that it set a *threshold* of $40,000 in total audited charges.

The Staff Report recognized that at least as early as 2004 the $40,000 threshold no longer achieved effective medical cost control. "When the Commission initially adopted this rule, approximately 3% of workers' compensation hospitals stays met the threshold of $40,000. The charges associated with these hospital stays represented 17% of all billed hospital inpatient charges (excluding trauma cases). These few hospital stays were presumed to represent unusually extensive services. In reviewing the data for 2004, more than 28% of hospital stays met this threshold, representing more than 65% of all billed charges (excluding trauma cases). This large percentage increase indicates that a hospital charge of $40,000 or more is no longer, by itself, a good indicator that a hospital stay involves unusually extensive services."

The notice of proposed repeal alludes to these facts but does not finish the story, in two important ways.

First, $40,000 does not limit payment at 75% of total audited charges to unusually extensive services because hospitals set their own charges, unregulated. If there is no other limit than charges above $40,000, the stop-loss exception allows hospitals to require that they be paid more simply by the hospital charging more.

That does not achieve effective medical cost control. Indeed, it delegates the DWC's government function of setting hospital payments to the hospitals themselves. DWC data indicate that the amount in controversy (claimed by hospitals at 75% of charges in matters in which charges exceeded $40,000, less amounts paid at per diem plus carve-outs) in the more than 1400 pending fee disputes exceeds $70 million.

Second, the DWC in the Staff Report dealt with the failure of the $40,000 total audited charge threshold to achieve medical cost control by adopting the interpretation that the 1997 fee rule authorized and required the DWC to "determine whether or not the hospital stay involved unusually extensive services on a case-by-case basis." Vista challenged this interpretation. The Hon. Margaret Cooper ruled for Vista, and the DWC has elected not to appeal.

Repeal of the 1997 hospital fee rule is therefore a reasonable, indeed required, means to address the statutory objective of effective medical cost control for all pre-March 1, 2008 admissions.

Effect of Repeal of the 1997 Hospital Fee Rule:

The DWC's notice of proposed repeal states that: "Section 134.401 no longer meets the needs of the workers' compensation system. Since section 134.401 will no longer be needed after March 1, 2008, the DWC proposes the repeal of section 134.401." 33 Tex. Reg. 1487 (Feb. 22, 2008). The DWC clearly and understandably seeks to put the stop-loss exception debacle behind the Texas workers' compensation system, and intends repeal of the 1997 hospital fee rule for that purpose. The DWC should more fully explain the effect of the repeal to avoid additional litigation and encourage settlements.

The DWC's default rule will control pending cases – After the repeal of § 134.401, for admissions occurring before March 1, 2008 for which reimbursement has been timely disputed and the dispute has not been finally and non-appealably resolved, there will be no applicable fee guideline setting a specific maximum allowable reimbursement.

In such a case, DWC rule § 134.1 applies. *All Saints Hospital System v. Texas Workers' Compensation Commission*, 125 S.W.3d 96 Tex. App – Austin 2003, pet. denied).

DWC rule § 134.1 subsections (c)(3)-(d) require that in the absence of an applicable fee guideline setting a specific MAR, fair and reasonable reimbursement must be "consistent with the criteria of Labor Code § 413.011."

Specifying the effect of repeal will discourage additional wasteful litigation – Vista and perhaps other hospitals may challenge the application of the default rule to the admissions before March 1, 2008 for which fee disputes are pending. The DWC can and should reduce this litigation risk by specifying that the default rule controls.

The United States Supreme Court has held that "a court is to apply the law in effect at the time it renders its decision, unless doing so would result in manifest injustice or there is statutory direction or legislative history to the contrary." *Bradley v. School Board of Richmond*, 94 S.Ct. 2006, 2016 (1974).

There is nothing manifestly unjust about a hospital being paid a fee that is fair and reasonable under the statutory standards, as DWC rule § 134.1 subsections (c)(3)-(d) require. The statutory standards define what is a fair and reasonable fee.

In the absence of clarification of the effect of the repeal, Vista and any allies may argue that, despite the repeal of the 1997 fee rule, there is direction or intent by the DWC that the 1997 fee rule continue to control all admissions before March 1, 2008, and that DWC rule § 134.1 subsections (c)(3)-(d) would not control still-pending fee disputes over admissions occurring before March 1, 2008.

The DWC should dispose of this risk by including the following language in its repeal of 28 Tex. Admin Code § 134.401:

"After the repeal of 28 Tex. Admin. Code. §134.401, for inpatient hospital admissions occurring before March 1, 2008 for which medical fee disputes are timely filed and pending at the Medical Review DWC, at the State Office of Administrative Hearings, or in court, determinations whether additional payment is due will be governed by DWC rule 134.1(c)(3)-(d), which makes applicable the Labor Code section 413.011 statutory reimbursement standards."

Clarifying that repeal applies to pending cases is necessary to moot the SLX litigation – Repeal of the 1997 hospital inpatient fee rule, resulting in application of the statutory standards pursuant to DWC rule § 134.1(c)(3)-(d), will moot all pending stop loss exception litigation. Failure to make the repeal result in the application of DWC rule § 134.1(c)(3)-(d) would mean that the litigation will continue for years more, and then end in the same way – application of DWC rule § 134.1(c)(3)-(d).

After the DWC's decision not to appeal, the core of the pending litigation is about the validity of the 1997 fee rule's stop-loss exception assuming that exception only requires hospital charges exceeding $40,000. Repeal making DWC rule § 134.1(c)(3)-(d) control all fee disputes on pre-March 1, 2008 admissions moots that litigation.

If, however, Vista challenges the effectiveness of repeal to make DWC rule § 134.1(c)(3)-(d) control all fee

disputes on pre-March 1, 2008 admissions, and if Vista prevails, then it will be necessary for the courts to determine the validity of a rule that only requires that total audited charges exceed $40,000 and does not regulate charges. It will be at least 2009 and perhaps 2010 before the Third Court of Appeals issues its decision, and petitions for review by the Texas Supreme Court may postpone a final decision until 2011 and 2012

Repeal specifying that DWC rule § 134.1(c)(3)-(d) controls will encourage SLX settlements – If the DWC specifies in repealing the 1997 hospital fee rule that DWC rule § 134.1(c)(3)-(d) controls fee disputes over pre-March 1, 2008 admissions, and moots the pending litigation over the 1997 fee rule's exception, this will encourage prompt settlements of what is "fair and reasonable" payment for such disputes, at or near the DWC's new Medicare-based fee rule fees.

This is the best hope the DWC has to encourage settlements of the more than 1,400 stop-loss exception fee disputes its data show as pending, at levels that the DWC's new Medicare-based fee rule indicates are fair and reasonable.

Request for Meeting With Commissioner Betts to Discuss ICT's Supplemental Comments

ICT would like to meet with Commissioner Betts to discuss the fore-going comments and related issues prior to the commissioner taking action on the proposed rule repeal.

Please contact me and let it know if it is possible to meet with Commissioner Betts and what date(s) and time(s) he has available to meet.

Respectfully,

Steven W. Nichols

Manager, Workers' Compensation Services

Insurance Council of Texas

Tel. No.: (512) 326-7618 or 444-9611

Fax. No.: (512) 444-0734

E-mail: snichols@insurancecouncil.org

4

PRINGLE & GALLAGHER, L.L.P.
THE VAUGHN BUILDING
807 BRAZOS, SUITE 200
AUSTIN, TEXAS 78701
TELEPHONE (512) 472-8742
FACSIMILE (512) 472-8745
E-MAIL: JOHNDPRINGLE@SBCGLOBAL.NET

PLEASE FILE STAMP AND RETURN

JOHN D. PRINGLE, P.C. *
* John D. Pringle - Board Certified - Administrative Law
Texas Board of Legal Specialization

LAURIE S. GALLAGHER, P.C.

March 24, 2008
Via Hand Delivery

The Honorable Albert Betts
Commissioner of Workers' Compensation
Texas Department of Insurance
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

Re: Division Proposed Repeal of existing Rule 134.401, Acute Care Inpatient Hospital Fee Guideline.

Dear Commissioner Betts:

Please allow this letter to serve as my written comments regarding the proposed repeal of existing Rule 134.401, the Acute Care Inpatient Hospital Fee Guideline, which was adopted in 1997. I make these written comments to the proposed repeal hoping you and the Division of Workers' Compensation will give them due consideration. The purpose of my written comments is to set out recommended changes to the proposed order of repeal. My recommended changes to the proposed order of repeal are to provide consistency and clarity in conjunction with other Division of Workers' Compensation rules.

As you know, Texas Government Code Section 2001.003 (6) (B) defines a "rule" as including "the amendment or repeal of a prior rule." Texas Government Code Section 2001.039 (d) provides that the procedures of the Government Code relating to the original adoption of a rule apply to the repeal of a rule. Those procedures are found in part in Texas Government Code Section 2001.033, State Agency Order Adopting Rule, which provides in part:

(a) A state agency order finally adopting a rule must include:

(1) a reasoned justification for the rule as adopted consisting solely of:

(A) a summary of comments received from parties interested in the rule that shows the names of interested groups or associations offering comment on the rule and whether they were for or against its adoption;

(B) a summary of the factual basis for the rule as adopted which demonstrates a rational connection between the factual basis for the rule and the rule as adopted; and

(C) the reasons why the agency disagrees with party submissions and proposals;

(2) a concise restatement of the particular statutory provisions under which the rule is adopted and of how the agency interprets the provisions as authorizing or requiring the rule; and

(3) a certification that the rule, as adopted, has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Please note that I support the repeal of current Rule 134.401. However, please take note that I disagree with the following statement found in the notice of the proposed repeal.

> Instead of per diem reimbursement, the stop-loss provision of §134.401(c) (6) provided for a reimbursement of 75% of total audited charges if those charges exceeded $40,000.

Heretofore it has been the Division of Workers' Compensation's position that the stop-loss method is to be used for "unusually costly services" as established in Rule 134.401(c)(6). The Texas Workers' Compensation Commission, the predecessor agency to the Division of Workers' Compensation, has in the past stated that in order "to determine if 'unusually costly services' were provided, the admission (or hospital stay) must: (1) not only exceed $40,000 in total audited charges, but (2) also involve 'unusually extensive services.'" Texas Workers' Compensation Commission Medical Dispute Resolution Newsletter Issue No: 5 Date: (April 2005).

The Division of Workers' Compensation should make it clear that it has abandoned or repudiated the foregoing position. In the alternative, the Division of Workers' Compensation should state in its reasoned justification for repeal of current Rule 134.401 that the foregoing position was a mistake or it was never the position of the agency and that the only requirement for stop-loss reimbursement for an inpatient admission was that after audit, the total audited charges exceeded $40,000.00.

In the notice of the proposed repeal, the Division of Workers' Compensation states the basis for said repeal:

> In 2001, the Legislature passed House Bill 2600, which amended Labor Code §413.011 by directing the Texas Workers' Compensation Commission to adopt a reimbursement structure modeled along the lines of the Medicare system.
>
> In accordance with that directive, the Division recently adopted §134.403, concerning Hospital Fee Guideline – Outpatient and §134.404, concerning Hospital Facility Fee Guideline – Inpatient, which will supersede the provisions of §134.401 on and after March 1, 2008. Section 134.403 and §134.404 implemented Labor Code §413.011 by adopting a standardized reimbursement

structure using in part the most current methodologies, models, values and weights used by the Centers for Medicare and Medicaid Services (CMS).

Section 134.401 no longer meets the needs of the workers compensation system. Since §134.401 will no longer be needed after March 1, 2008, the Division proposes the repeal of §134.401.

The Division of Workers' Compensation should make it clear that it had not adopted an inpatient hospital fee guideline in compliance with House Bill 2600 until 2008. In addition, the Division of Workers' Compensation should address how the pre-March 1, 2008, pending alleged stop-loss exception cases will be handled by the Division of Workers' Compensation. It is my opinion, that with the repeal of Rule 134.401, Division of Workers' Compensation Rule 134.1 will apply to the pending alleged stop-loss exception cases.

In addition, it is my understanding that the issue in the pending alleged stop-loss exception cases will be what it has always been, to wit: whether the health care provider is entitled to additional reimbursement. Another way of stating the issue is whether insurance carrier's reimbursement to the health care provider complied with the statutory standards found in Texas Labor Code Section 413.011. If the Division of Workers' Compensation disagrees with my opinions, then I would request the Division of Workers' Compensation state the basis and authority for its disagreement.

If you or the Division of Workers' Compensation Staff have any questions, comments or just wish to discuss my comments, please do not hesitate to contact me. Again, thank you for the opportunity to provide you and the Division of Workers' Compensation Staff with my comments to the proposed repeal of Rule 134.401.

By copy of this letter I am advising Victoria Ortega of this correspondence.

Very truly yours,

John D. Pringle

JDP/

cc: Victoria Ortega
Legal Services, MS-4D
Texas Department of Insurance,
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

Via Hand Delivery

f:\jdp\twcc\repeal ACIHFG ltr 3-24-08

5

C

Effective: September 1, 2007

Vernon's Texas Statutes and Codes Annotated Currentness
Labor Code (Refs & Annos)
Title 5. Workers' Compensation
Subtitle A. Texas Workers' Compensation Act
Chapter 413. Medical Review
Subchapter B. Medical Services and Fees (Refs & Annos)
→ **§ 413.011. Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols**

(a) 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.

(b) In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). The commissioner shall also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and commissioner rules. This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.

(c) This section may not be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Sections 1451.104(a) and (c), Insurance Code, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle. The commissioner shall also develop guidelines relating to fees charged or paid for providing expert testimony relating to an issue arising under this subtitle.

(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.

<Text of subsec. (d-1) effective until January 1, 2011>

(d-1) Notwithstanding Subsections (b) through (d) and Section 413.016, an insurance carrier may pay fees to a health care provider that are inconsistent with the fee guidelines adopted by the division if the insurance carrier,

or a network under Chapter 1305, Insurance Code, arranging out-of-network services under Section 1305 006, Insurance Code, has a contract with the health care provider and that contract includes a specific fee schedule An insurance carrier or the carrier's authorized agent may use an informal or voluntary network, as those terms are defined by Section 413 0115, to obtain a contractual agreement that provides for fees different from the fees authorized under the division's fee guidelines. If a carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual fee arrangement, there must be a contractual arrangement between:

(1) the carrier or authorized agent and the informal or voluntary network that authorizes the network to contract with health care providers on the carrier's behalf; and

(2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements established under Subsection (d-2).

<Text of subsec. (d-2) effective until January 1, 2011>

(d-2) An informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, shall notify each health care provider of any person that is given access to the network's fee arrangements with that health care provider within the time and according to the manner provided by commissioner rule

<Text of subsec. (d-3) effective until January 1, 2011>

(d-3) An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. Information included in a contract under Subsection (d-1) is confidential and is not subject to disclosure under Chapter 552, Government Code. For medical fee disputes that arise regarding non-network and out-of-network care, the division may request that copies of each contract under which fees are being paid be submitted to the division for review. Notwithstanding Subsection (d-1) or Section 1305 153, Insurance Code, the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract:

(1) is not provided in a timely manner to the division on the division's request;

(2) does not include a specific fee schedule consistent with Subsection (d-1); and

(3) does not:

(A) clearly state that the contractual fee arrangement is between the health care provider and the named insurance carrier or the named insurance carrier's authorized agent; or

(B) comply with the notice requirements under Subsection (d-2).

<Text of subsec. (d-4) effective January 1, 2011>

(d-4) Notwithstanding this section or any other provision of this title, an insurance carrier, an insurance carrier's authorized agent, or a network certified under Chapter 1305, Insurance Code, arranging for non-network services or out-of-network services under Section 1305 006, Insurance Code, may continue to contract with a

health care provider to secure health care for an injured employee for fees that exceed the fees adopted by the division under this section.

(d-5) The commissioner and the commissioner of insurance may adopt rules as necessary to implement this section.

<Text of subsec. (d-6) effective until January 1, 2011>

(d-6) Subsections (d-1) through (d-3) and this subsection expire January 1, 2011.

(e) The commissioner by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols. Treatment guidelines and protocols must be evidence-based, scientifically valid, and outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines.

(f) In addition to complying with the requirements of Subsection (e),

medical policies or guidelines adopted by the commissioner must be:

(1) designed to ensure the quality of medical care and to achieve effective medical cost control;

(2) designed to enhance a timely and appropriate return to work; and

(3) consistent with Sections 413.013, 413.020, 413.052, and 413.053.

(g) The commissioner may adopt rules relating to disability management that are designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes through appropriate management of work-related injuries or conditions. The commissioner by rule may identify claims in which application of disability management activities is required and prescribe at what point in the claim process a treatment plan is required. The determination may be based on any factor considered relevant by the commissioner. Rules adopted under this subsection do not apply to claims subject to workers' compensation health care networks under Chapter 1305, Insurance Code.

(h) A dispute involving a treatment plan required under Subsection (g) may be appealed to an independent review organization in the manner described by Section 413.031.

(i) The division shall examine whether injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues and investigate whether reimbursement rates or any other barriers exist that reduce the ability of an injured employee to access those medical needs. The division shall recommend to the legislature any statutory changes necessary to ensure appropriate access to those medical needs.

CREDIT(S)

Acts 1993, 73rd Leg., ch. 269, § 1, eff. Sept. 1, 1993. Amended by Acts 2001, 77th Leg., ch. 1456, § 6.02, eff. June 17, 2001; Acts 2003, 78th Leg., ch. 962, §§ 1, 2, eff. June 20, 2003; Acts 2005, 79th Leg., ch. 265, § 3.233, eff. Sept. 1, 2005; Acts 2005, 79th Leg., ch. 728, § 11.143, eff. Sept. 1, 2005; Acts 2007, 80th Leg., ch. 1177, § 2, eff. Sept. 1, 2007.

Current through the end of the 2007 Regular Session of the 80th Legislature

END OF DOCUMENT

(2) services;
(3) fees; and
(4) charges.

(b) The commission shall keep confidential information that is confidential by law.

(c) An insurance carrier commits a violation if the insurance carrier fails or refuses to comply with a request or violates a rule adopted to implement this section. A violation under this subsection is a Class C administrative violation. Each day of noncompliance constitutes a separate violation.

ED: Carrier failure to provide information regarding, or failure to follow a rule regarding, medical review is Class "C" Administrative Violation, maximum $1,000 fine for each day of noncompliance

SUBCHAPTER B. MEDICAL SERVICES AND FEES

Sec. 413.011. REIMBURSEMENT POLICIES AND GUIDELINES; TREATMENT GUIDELINES.

(a) The commission shall use 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 commission shall adopt the most current reimbursement methodologies, models, and values or weights used by the federal Health Care Financing Administration, 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.

(b) In determining the appropriate fees, the commission shall also develop conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). The commission shall also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and commission rules. This section does not adopt the Medicare fee schedule, and the commission shall not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Health Care Financing Administration.

(c) This section may not be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Section 3(d), Article 21.52, Insurance Code, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle. The commission shall also develop guidelines relating to fees charged or paid for providing expert testimony relating to an issue arising under this subtitle.

(d) Guidelines for medical services fees 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 commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

(e) The commission by rule may adopt treatment guidelines, including return-to-work guidelines. If adopted, treatment guidelines adopted must be nationally recognized, scientifically valid, and outcome-based and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care.

(f) The commission by rule may establish medical policies or treatment guidelines relating to necessary treatments for injuries.

(g) Any medical policies or guidelines adopted by the commission must be:
(1) designed to ensure the quality of medical care and to achieve effective medical cost control;
(2) designed to enhance a timely and appropriate return to work; and
(3) consistent with Sections 413.013, 413.020, 413.052, and 413.053.

ED: This section was radically revised by the 2001 Legislature and requires the Commission to use health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems, and requires the Commission to adopt the most current reimbursement methodologies, models, and values or weights used by the Federal Health care Financing Administration, including applicable payment policies related to coding, billing, and

reporting. The Commission is required to adopt the rules and fee guidelines authorized by this section not later than May 1, 2002. The Commission's previous mandatory requirement for the adoption of treatment guidelines and return to work guidelines was made discretionary. The previous treatment guidelines are abolished effective January 1, 2002

Sec. 413.012 MEDICAL POLICY AND GUIDELINE UPDATES REQUIRED.
The medical policies and fee guidelines shall be reviewed and revised at least every two years to reflect fair and reasonable fees and to reflect medical treatment or ranges of treatment that are reasonable or necessary at the time the review and revision is conducted.

ED: The commission shall review and revise the medical policies and fee guidelines under Section 413.011 at least every two years with the advice of the medical advisory committee.

Sec. 413.013. PROGRAMS.
The commission by rule shall establish:

(1) **a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services;**

(2) **a program for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments or services, including the authorization of prospective, concurrent, or retrospective review under the medical policies of the commission to ensure that the medical policies or guidelines are not exceeded;**

(3) **a program to detect practices and patterns by insurance carriers in unreasonably denying authorization of payment for medical services requested or performed if authorization is required by the medical policies of the commission; and**

(4) **a program to increase the intensity of review for compliance with the medical policies or fee guidelines for any health care provider that has established a practice or pattern in charges and treatments inconsistent with the medical policies and fee guidelines.**

ED: The commission is required to establish programs for medical dispute resolution, for monitoring fees and necessity of treatment, to detect unreasonable denial for treatment authorization by carriers, and to intensify review of potentially abusive healthcare providers.

Sec. 413.014. PREAUTHORIZATION REQUIREMENTS; CONCURRENT REVIEW AND CERTIFICATION OF HEALTH CARE.

(a) **In this section, "investigational or experimental service or device" means a health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.**

(b) **The commission by rule shall specify which health care treatments and services require express preauthorization or concurrent review by the insurance carrier. Treatments and services for a medical emergency do not require express preauthorization.**

(c) **The commission rules adopted under this section must provide that preauthorization and concurrent review are required at a minimum for:**
- (1) **spinal surgery, as provided by Section 408.026;**
- (2) **work-hardening or work-conditioning services provided by a health care facility that is not credentialed by an organization recognized by commission rules;**
- (3) **inpatient hospitalization, including any procedure and length of stay;**
- (4) **outpatient or ambulatory surgical services, as defined by commission rule; and**
- (5) **any investigational or experimental services or devices.**

(d) **The insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commission.**

6

includes the documentation requirement under Rule 133 1(a)(3)(E). When the carrier returns a bill because it is incomplete, the Rule requires that the carrier include a letter that explains all of the specific reasons for the return. The carrier must be able to prove the date that the letter was sent. If the bill was incomplete, and the carrier was required to return it, the bill is not considered to have been submitted to the carrier. Any resubmission constitutes a new bill, and if not timely resubmitted pursuant to Rule 134 801(c), the carrier is not liable for payment. If the carrier fails to review the bill within the seven day period, and the bill is incomplete, the rule does not indicate whether the carrier can return the bill at that time. However, failure to properly review the bill and determine the completeness of it is an administrative violation on the part of the carrier.

Rule 133.301. Retrospective Review of Medical Bills.

(a) The 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 Commission fee and treatment guidelines. The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title (relating to Guidelines for Medical Services, Charges, and Payments). The insurance carrier may conduct a retrospective review of a medical bill at the insurance carrier's location or through an onsite audit of the health care provider as provided by §133.302 and §133.303 of this title (relating to Preparation for an Onsite Audit and Onsite Audits). The retrospective review may include examination for:
- (1) compliance with the fee guidelines established by the Commission;
- (2) compliance with the treatment guidelines established by the Commission;
- (3) duplicate billing;
- (4) upcoding and/or unbundling;
- (5) billing for treatment(s) and/or service(s) unrelated to the compensable injury;
- (6) billing for services not documented or substantiated, when documentation is required in accordance with Commission fee guidelines or rules in effect for the dates of service;
- (7) accuracy of coding in relation to the medical record and reports;
- (8) correct calculations; and/or
- (9) provision of unnecessary and/or unreasonable treatment(s) and/or service(s).

(b) Neither the insurance carrier nor the carrier's agent shall change a billing code on a medical bill or reimburse treatment(s) and/or service(s) at another billing code's value unless the insurance carrier contacts the sender of the bill and the sender agrees to the change.
- (1) If the sender of the medical bill agrees to a specific change in a billing code, the insurance carrier shall make the change on the medical bill and use that code in the electronic transmission of the medical bill data to the Commission under §134.802 of this title (relating to Insurance Carrier's Submission of Medical Bills to the Commission).
- (2) If the insurance carrier changes a billing code with the agreement of the sender, the insurance carrier shall maintain documentation regarding the manner in which the agreement was reached, the name and telephone number of the person who agreed to the change, and the date the agreement was reached.

(c) An insurance carrier shall not request documentation on a medical bill unless:
- (1) the documentation is required in accordance with the Commission fee guidelines or rules in effect for the dates of service;
- (2) the health care provider has not filed required medical reports that the insurance carrier needs to conduct a retrospective review;
- (3) the employee has not selected a treating doctor; or
- (4) the employee seeks emergency treatment, and the insurance carrier requires documentation of the emergency treatment.

(d) An insurance carrier's request for additional documentation shall:
- (1) clearly indicate the specific documentation the insurance carrier is requesting;
- (2) indicate the specific reason for which the insurance carrier is requesting the information;
- (3) include a copy of the bill for which the insurance carrier is requesting the additional documentation;
- (4) be made by, facsimile, mutually agreed upon electronic transmission, or telephone; if by telephone, the insurance carrier shall document the name and telephone number of the person who supplied the information; and

ADOPTED RULES

(5) be made not later than the 14th day after receipt of the medical bill.

(e) The insurance carrier shall maintain a copy of the request for additional documentation or be able to electronically reproduce it and shall maintain documentation of the date the insurance carrier sent the request to the health care provider.

(f) A health care provider shall submit to the insurance carrier, no later than the 14th day after receipt of a request for additional documentation in accordance with this section, any additional documentation, records, or information related to the treatment(s) and/or service(s) rendered, or the charges billed. If the insurance carrier requests documentation that the health care provider does not have, the health care provider shall send the insurance carrier a notice to that effect within 14 days after the date the health care provider received the request. The health care provider shall send documentation and notice provided by this subsection to the insurance carrier by facsimile or mutually agreed upon electronic transmission unless the requested documentation cannot be sent by those media, in which case the health care provider shall send the documentation by mail or personal delivery.

(g) A health care provider's failure to timely provide an insurance carrier with additional documentation submitted in accordance with this section does not extend the amount of time the insurance carrier has to make payment or deny payment on a bill in accordance with §133.304 of this title (relating to Payments and Denials of Medical Bills).

(h) This rule shall apply to all dates of service on or after July 15, 2000.

Effective Date: February 20, 1992 (17 Tex. Reg. 1105)
Amended Effective Date: July 15, 2000 (25 Tex. Reg. 2115)
Emergency Rule Amended Effective Date: November 3, 2005 (30 Tex. Reg. 7621)

Ed: The 2000 amendments define the carrier's responsibilities when reviewing a medical bill for reimbursement. Subsection (a) provides for the retrospective review of all completed medical bills for compliance with the Texas Labor Code, Commission fee and treatment guidelines, and other Commission rules. However, a carrier's prospective review of medical necessity and reasonableness of treatments or services through the preauthorization process establishes the medical necessity and reasonableness of the treatment, and the carrier is not allowed to reconsider this issue retrospectively. If the carrier had preauthorized a service that it was required to preauthorize, the carrier is liable for remitting a reasonable reimbursement for the service.

Pursuant to Rule 133.1, a medical bill requires certain supporting documentation. This Rule, prior to the 2005 emergency amendments, specified the circumstances in which a carrier could request additional documentation (which the carrier had to make within fourteen days). Rule 133.300 states that carriers must, upon receipt of a bill, review the bill for completeness, according to the definition in Rule 133.1. If the bill is complete, the time that is allowed for the carrier to process the bill continues to run. Where a health care provider does not send sufficient documentation, and does not respond timely to the carrier's request for additional documentation, but the bill is nevertheless complete pursuant to the definition contained in Rule 133.1, the carrier must still review the bill based on the information available. If the information does not support the level of service for which the provider billed, the carrier may deny payment for the bill. This does not change the carrier's statutory 45-day time frame to process the bill.

The rule as published reflects the 2005 emergency rule amendments, which: deleted a sentence in subsection (a) regarding onsite audits to clarify that the timeframes apply to all audits; deleted the criteria in subsection (c) that must be met for an insurance carrier to request additional documentation on a medical bill since a carrier may request additional documentation necessary to clarify a provider's charges at any time during the 45-day period; and changed the timeframe a provider has to respond to a request for additional documentation to 15 days from 14 days. The various timeframes set forth in these sections are consistent with the timeframes established by those amendments. Amendments were also been made throughout the rule to update references and revise effective dates.

Rule 133.302. Preparation for an Onsite Audit.

(a) An insurance carrier may perform an onsite audit of a health care provider that has billed the insurance carrier, if the insurance carrier provides a notice of intent to perform an onsite audit in accordance with subsections (c) and (d) of this section.

(b) An onsite audit may focus on workers' compensation claims in which the insurance carrier:

7

ment in accordance with §116.11 of this title (relating to Request for Reimbursement or Payment from the Subsequent Injury Fund).

(g) This rule shall apply for all requests submitted on or after July 15, 2000.

Effective Date: July 15, 2000

Ed: This rule implements 1999 Legislation and allows the Executive Director to delegate the authority to issue interlocutory orders for the payment of medical benefits denied on the basis that they are not compensable or not reasonable and necessary. The Benefit Review Officers and Hearing Officers continue to have authority to issue interlocutory orders for the payment of medical benefits on the basis that they are for non-compensable conditions

SUBCHAPTER E - COMPELLING PRODUCTION OF DOCUMENTS

Rule 133.401: Orders for Production of Documents

(a) The executive director or designee may issue an order for the production of documents upon the written request of an employee of the medical review division which establishes good cause for issuance.

(b) The request for issuance of an order for the production of documents shall be sufficient to establish good cause if it contains:

(1) a description of the documents sought with adequate particularity;

(2) the name of the person believed to be in possession of the documents and the address or location where the documents are believed to be; and

(3) a statement that such documents are needed in an identified matter.

(c) An order for the production of documents may be issued at any time to obtain documents relating to a matter within the authority of the division of medical review.

Effective Date: June 1, 1992

Rule 133.402: Delivery of Order; Compliance

(a) Service shall be completed by delivery of a copy of the order to the individual named in the order, in person or by certified mail, return receipt requested.

(b) The individual served shall comply with the order on or before the time and date stated in the order by providing the described documents to the designated agency employee. Copies of such documents may be substituted for originals.

Effective Date: June 1, 1992

Rule 133.403: Noncompliance; Enforcement

(a) Noncompliance with an order for the production of documents is punishable as an administrative violation under Texas Civil Statutes, Article 8308-10.21(b)(3), with a penalty not to exceed $10,000.

(b) In addition to initiation of administrative violation proceedings, compliance with an order for the production of documents may be enforced by means of a civil proceeding filed in a district court in Travis County, Texas.

Effective Date: June 1, 1992

CHAPTER 134 - BENEFITS - GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER A - MEDICAL POLICIES

Rule 134.1: Use of the Fee Guidelines

(a) The ground rules and the medical service standards and limitations as established by the fee guidelines shall be used to properly calculate the payments due to the health care providers.

(b) Health care providers shall bill the insurance carrier for all compensable injuries using the codes from the fee guidelines established by the commission. The health care provider shall bill the insurance carrier for

the health care treatments and services performed, and medically necessary to relieve the effects of the compensable injury and promote recovery.

(c) Doctors of medicine, osteopathy, dentistry, chiropractic, podiatry, optometry, psychology, and registered nurses, physical therapists, occupational therapists, imaging or radiology centers, minor emergency centers, free-standing pathology centers, durable medical equipment suppliers, and orthotic and prosthetic suppliers shall bill the insurance carrier using the medical fee guideline described in Section 134.200 of this title (relating to Medical Fee Guideline).

(d) Pharmacists, in settings other than a hospital, shall bill according to the Pharmaceutical Fee Guideline described in Section 134.501 of this title (relating to Pharmaceutical Fee Guideline).

(e) Hospitals, licensed by Texas Department of Health or Texas Department of Mental health and Mental Retardation, and ambulatory surgical centers, licensed by Texas Department of Health, shall bill according to the Hospital and Ambulatory Surgical Center Fee Guideline described in Section 134.400 of this title (relating to Hospital and Ambulatory Surgical Center Fee Guideline).

(f) Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, Section 8.21(b), until such period that specific fee guidelines are established by the commission.

Effective Date: October 7, 1991

Rule 134.2: Insurance Carrier Responsibility to Submit Medical Reports.
An insurance carrier shall submit all medical reports and other documentation in its possession to the commission. A carrier that fails to submit requested information or that submits requested information late without good cause may be assessed an administrative penalty under the Texas Workers' Compensation Act, Section 8.04, 10.07(b)(22), and 10.21.

Effective Date: July 26, 1991

Rule 134.4. Definition of Consulting Doctor

Repealed Effective: March 13, 2000

Rule 134.5: Treating Doctor Attendance at Medical Examination Under a Medical Examination Order

(a) The injured employee's treating doctor may be present at a required medical examination as described in Section 126.6 of this title (relating to Order for Required Medical Examinations). The treating doctor shall be reimbursed by the insurance carrier for time as specified in the following guidelines:
  (1) a rate of $100.00 an hour limited to 4 hours of reimbursement of time or, if in excess of four hours, with prior approval from the insurance carrier,
  (2) reimbursement is limited to the time required to travel from the doctor's usual place of business to the place of the examination. In addition, it includes the duration of the examination and the time required to return from the examination location to the doctor's usual place of business (departure point). The travel shall be by the most direct route. This time does not include time spent for meals or other elective activities engaged in by the doctor.
  (3) the charge shall be calculated in quarter hour increments with any amount over ten minutes to be considered an additional quarter hour.

(b) A charge for attendance that exceeds these guidelines, shall have prior approval from the insurance carrier or the commission.

(c) After accompanying the injured employee to the examination, the treating doctor shall submit request for reimbursement on TWCC Form 67.

(d) The injured employee's treating doctor shall be the only doctor permitted to attend and charge for the attendance at the examination, unless the treating doctor receives prior approval from the insurance carrier to send a different doctor to observe the examination.

Effective Date: September 2, 1991

8

<<Prev Rule

Texas Administrative Code

Next Rule>>

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 134	BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS
SUBCHAPTER E	HEALTH FACILITY FEES
RULE §134.401	**Acute Care Inpatient Hospital Fee Guideline**

(a) Applicability.

(1) This guideline shall become effective August 1, 1997. The Acute Care Inpatient Hospital Fee Guideline (ACIHFG) is applicable for all reasonable and medically necessary medical and/or surgical inpatient services rendered after the effective date of this rule in an acute care hospital to injured workers under the Texas Workers' Compensation Act. These rules shall not apply to acute care hospitals which are located in a population center of less than 50,000 persons and have 100 or less licensed beds, which shall be reimbursed at a fair and reasonable rate.

(2) Psychiatric and/or rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline on these specific types of admissions. For these type of admissions, insurance carriers shall put one of the appropriate following codes on each bill to indicate the type of services performed: Type of Service--Code: Rehabilitation-Inpatient--IR; Psychiatric-Inpatient--IP.

(3) Services such as outpatient physical therapy, radiological studies, and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services. For these type of admissions, insurance carriers shall put one of the appropriate following codes on each bill to indicate the type of services performed: Type of Service--Code: Hospital Surgical-Outpatient--HS; Hospital Other-Outpatient--HO; Ambulatory Surgical- Outpatient--AS; Ambulatory Other-Outpatient--AO.

(4) Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements. For these type of admissions, insurance carriers shall put one of the appropriate following codes on each bill to indicate the type of services performed: Type of Service--Code: Ambulatory Surgical-Outpatient--AS; Ambulatory Other-Outpatient--AO.

(5) Emergency services that do not lead to an inpatient admission are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services. Except as listed in subsection (c)(4)(B) of this section, emergency transportation shall be reimbursed in accordance with the Texas Workers' Compensation Commission Medical Fee Guideline in effect at the time the services are rendered.

(b) General Ground Rules.

(1) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(A) Acute Care Hospital--A health care facility that provides inpatient or outpatient services delivered to

patients experiencing acute illness or trauma as licensed by the Texas Department of Health (TDH) as a General or Special Hospital Type.

(B) Inpatient Services--Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital.

(C) Institutional Services--All non-physician services rendered within the hospital by an employee or agent of the hospital.

(D) Length of Stay (LOS)--Number of calendar days from admission to discharge. In computing a patient's length of stay, the day of admission is counted, but the day of discharge is not.

(E) Medical Admission--Any hospital admission where the primary services rendered are medical in nature.

(F) Stop-Loss Payment--An independent method of payment for an unusually costly or lengthy stay.

(G) Stop-Loss Reimbursement Factor (SLRF)--A factor established by the Commission to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.

(H) Stop-Loss Threshold (SLT)--Threshold of total charges established by the Commission, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor by the total charges identifying that particular threshold.

(I) Surgical Admission--Any hospital admission where the primary services rendered are surgical in nature. The surgical nature of the service is indicated by the use of a surgical procedure code.

(J) 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.

(2) General Information.

(A) All hospitals shall bill their usual and customary charges. The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:

(i) a rate for worker's compensation cases pre-negotiated between the carrier and hospital;

(ii) the hospital's usual and customary charges; or

(iii) reimbursement as set out in subsection (c) of this section for that admission.

(B) Additional reimbursements as outlined in subsection (c)(4) of this section are determined on a case-by-case basis within the guidelines established for the specific services rendered.

(C) All charges submitted are subject to audit as described in Commission rules.

(D) All bills for professional services rendered by a health care practitioner shall be submitted on form TWCC-67, the standard HCFA 1500 form.

(E) All bills for acute care hospital inpatient services shall be submitted on form TWCC-68a, the standard UB-92 (HCFA 1450) form. Depending upon the type of service(s) rendered, the appropriate code shall be

included on each UB-92 (HCFA 1450) submitted. One of the following codes shall be put on the bill by the insurance carrier: Type of Service--Code: Acute Care-Inpatient (Medical)--IM; Acute Care-Inpatient (Surgical)--IS.

(F) When a medical admission takes place, and surgery is subsequently performed during this stay, the entire stay is considered to be a surgical admission.

(c) Reimbursement.

(1) Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical--$870; Surgical--$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU)--$1,560.

(2) Method. All 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.

(A) The complete treatment of an injured worker is categorized into two admission types: medical or surgical. A per diem amount shall be determined by the admission category.

(B) A per diem amount is also established for reimbursement of each specific ICU/CCU day independently. This special per diem rate is used for each ICU/CCU day in lieu of the specific (medical/surgical) per diem rate being used for normal services rendered during this admission.

(C) Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection or if the ICD-9 primary diagnosis code is listed in paragraph (5) of this subsection.

(3) Reimbursement Calculation.

(A) Explanation.

(i) Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical).

(ii) The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission.

(iii) If applicable, ICU/CCU days are subtracted from the total LOS and reimbursed the ICU/CCU per diem rate for those specific days of treatment in lieu of the assigned medical/surgical per diem rate.

(iv) The Workers' Compensation Reimbursement Amount (WCRA) is the total amount of reimbursement to be made for that particular admission.

(B) Formula. LOS x SPDA = WCRA.

(C) Examples.

(i) Without ICU/CCU days: admission category--medical; length of stay--eight days; per diem (medical)--$870: eight days at $870 equals $6,960.

(ii) With ICU/CCU days: admission category--surgical; length of stay--15 days; ICU/CCU days--three days; per diem (surgical)--$1,118; per diem (ICU/CCU)--$1,560. Fifteen total days minus three ICU/CCU days

equals 12 surgical days. Twelve days at $1,118 plus three days at $1,560 equals $18,096

(4) Additional Reimbursements. All items listed in this paragraph shall be reimbursed in addition to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursements apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

(A) When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%:

(i) Implantables (revenue codes 275, 276, and 278); and

(ii) Orthotics and prosthetics (revenue code 274).

(B) When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate:

(i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619);

(ii) Computerized Axial Tomography (CAT scans) (revenue codes 350-352, 359);

(iii) Hyperbaric oxygen (revenue code 413);

(iv) Blood (revenue codes 380-399); and

(v) Air ambulance (revenue code 545).

(C) Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time.

(5) Reimbursement for Certain ICD-9 Codes. When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate:

(A) Trauma (ICD-9 codes 800.0-959.50);

(B) Burns (ICD-9 codes 940-949.9); and

(C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9).

(6) Stop-Loss Method. Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. This methodology shall be used in place of and not in addition to the per diem based reimbursement system. The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.

(A) Explanation.

(i) To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold.

(ii) This stop-loss threshold is established to ensure compensation for unusually extensive services required

during an admission.

(iii) If audited charges exceed the stop-loss threshold, reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%.

(iv) The Stop-Loss Reimbursement Factor is multiplied by the total audited charges to determine the Workers' Compensation Reimbursement Amount (WCRA) for the admission.

(v) Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are personal items (e.g., telephone, television). If an on-site audit is performed, charges for services which are not documented as rendered during the admission may be deducted. Items and services which are not related to the compensable injury may be deducted. The formula to obtain audited charges is as follows: Total Charges - Deducted Charges = Audited Charges.

(B) Formula. Audited Charges x SLRF = WCRA.

(C) Example. Total Charges: $108,000; Deducted Charges: $8,001; Audited Charges: $99,999. $99,999 x .75 = $74,999.25 (WCRA)

(7) Reimbursement for Other Services.

(A) Professional Services. All professional services performed by a health care practitioner shall be reimbursed in accordance with the Texas Workers' Compensation Commission Medical Fee Guideline currently in effect.

(B) Pharmacy Services. Pharmaceutical services rendered as part of inpatient institutional services are included in the basic reimbursement established by paragraph (1) of this subsection. Pharmaceutical services shall not be reimbursed separately except as listed in paragraph (4)(C) of this subsection.

Source Note: The provisions of this §134.401 adopted to be effective August 1, 1997, 22 TexReg 6264.

Next Page Previous Page

List of Titles Back to List

HOME | TEXAS REGISTER | TEXAS ADMINISTRATIVE CODE | OPEN MEETINGS | HELP |

9

The amendment was adopted under the Texas Appraiser Licensing and Certification Act, §5 (Article 6573a 2, V.T.C.S.) which provides the Texas Appraiser Licensing and Certification Board with authority to adopt rules for the licensing and certification of real estate appraisers and for standards of practice.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on June 24, 1997.

TRD-9708230
Renil C. Liner
Commissioner
Texas Appraiser Licensing and Certification Board
Effective date: July 14, 1997
Proposal publication date: May 6, 1997
For further information, please call: (512) 465–3950

♦ ♦ ♦

Part XXIII. Texas Real Estate Commission

Chapter 535. Provisions of the Real Estate License Act

Education, Experience, Educational Programs, Time Periods, and Type of License

22 TAC §535.61

The Texas Real Estate Commission adopts an amendment to §535.61, concerning acceptance of courses submitted by real estate license applicants, with changes to the proposed text as published in the April 1, 1997, issue of the *Texas Register* (22 TexReg 3200). The amendment authorizes the commission to accept courses offered by a school accredited by the real estate regulatory body of another state. The amendment also permits the commission to accept real estate related courses from accredited colleges or universities for which credit was awarded on an examination only or because of other learning experience. Core real estate courses, those courses specifically required for original licensing or license renewal, would not be accepted by the commission if credit was given based only upon an examination or upon other learning experience. The caption of the section also has been broadened to include the acceptance of courses as well as examinations. Adoption of the amendment permits otherwise qualified applicants to rely upon education obtained in proprietary schools regulated by other states and to rely upon credits for real estate related courses obtained by examination or for other learning experience from an accredited college or university.

Three comments were received from individuals in support of the amendment. Two of the comments focused on the standards followed by colleges and universities in awarding credits based upon on-the-job training or other experience. On final adoption, the commission determined that the acceptance of course credits based on examination only or for other learning should be restricted to accredited colleges or universities, whose accreditation standards ensure the application of guidelines for the awarding of credits in this fashion. The commission also made nonsubstantive changes to make the section easier to read.

The amendment is adopted under Texas Civil Statutes, Article 6573a, §5(h), which authorize the Texas Real Estate Commission to make and enforce all rules and regulations necessary for the performance of its duties.

§535.61 Examinations and Acceptance of Courses.

(a)-(o) (No change.)

(p) Educational programs or courses of study in real estate offered after the effective date of this section by schools accredited by the commission, by a school accredited by a real estate regulatory agency of another state or by accredited colleges and universities, as defined by these sections, will be accepted as meeting the requirements of the Act for the successful completion of educational prerequisites for a license upon a determination by the commission that:

(1)-(5) (No change.)

(q)-(dd) (No change.)

(ee) The commission may accept experiential learning credits or credits awarded by final course examination only for real estate related courses from an accredited college or university. The commission may not accept experiential learning credits or credits awarded by final course examination only for core real courses from any source. Credits obtained from alternative delivery methods may be accepted by the commission if the course satisfies the requirements for such a course contained in §535.71 of this title (relating to Mandatory Continuing Education).

(ff)-(hh) (No change.)

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on June 24, 1997.

TRD-9708213
Mark A. Moseley
General Counsel
Texas Real Estate Commission
Effective date: July 14, 1997
Proposal publication date: April 1, 1997
For further information, please call: (512) 465–3900

♦ ♦ ♦

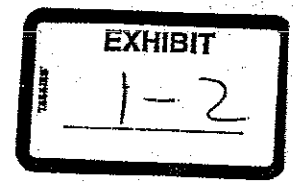
TITLE 28. INSURANCE

Part II. Texas Workers' Compensation Commission

Chapter 134. Guidelines for Medical Services, Charges, and Payments

Subchapter E. Health Facility Fees

28 TAC §134.400



The Texas Workers' Compensation Commission (The Commission or TWCC) adopts the repeal of §134.400 and new §134.401, concerning guidelines for acute care inpatient hospital fees and the simultaneous repeal of existing §134.400, concerning the same subject, with changes to the proposed text as published in the February 11, 1997, issue of the *Texas Register* (22 TexReg 1579).

The new rule will establish presumptively fair and reasonable payments for acute care inpatient hospital services provided after the effective date of the rule to workers' compensation claimants who were injured on or after January 1, 1991. Subsection (a) of the rule sets out the services to which the rule applies. Subsection (b) contains applicable definitions and general information related to billing for acute care inpatient hospital services. Subsection (c) sets out reimbursement amounts and methods, including reimbursement calculation examples, diagnoses and items which are carved out of the per diem reimbursement, stop-loss reimbursement method, and reimbursement for professional and pharmacy services.

As required by the Government Code §2001.033(1), the Commission's reasoned justification for this rule is set out in this order which includes the preamble, which in turn includes the rule. The reasoned justification is contained in this preamble, and throughout this preamble, including how and why the Commission reached the conclusions it did, why the rule is appropriate, the factual, policy, and legal bases for the rule, a restatement of the factual basis for the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rule, and the reasons why the Commission disagrees with some of the comments and proposals.

In formulating the Acute Care Inpatient Hospital Fee Guideline (ACIHFG), the Commission carefully and fully analyzed all of the statutory and policy standards and objectives and all the data and information the Commission has or which was submitted to it. The Commission utilized all of this, and its expertise and experience, to formulate the hospital fee guideline which balances the statutory standards to ensure that injured workers receive the quality health care reasonably required by the nature of their injury as and when needed; to ensure that the fee guidelines are fair and reasonable; to meet the statutory objective to achieve effective medical cost control; to ensure that the fee paid for a workers' compensation patient would not be 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 someone acting on that individual's behalf; and to take into consideration increased security of payment under the Texas Workers' Compensation Act (the Act). Full and objective analysis and consideration was given to all comments received, as evidenced by the revisions made to the rule as initially proposed and reproposed and the Commission's responses to comments in this preamble.

Some commenters advocated that the ACIHFG not be adopted. It is important that a guideline for acute care inpatient hospital services be adopted so the statutory standards discussed at the beginning of and throughout this preamble are complied with and it is of particular importance because of the invalidation of the previous ACIHFG by the courts. As a result, there has been no ACIHFG in place since the Texas Supreme Court's ruling on February 13, 1997, leaving the initial determination of what is a fair and reasonable rate to workers' compensation participants. This new ACIHFG will reduce the number of disputes and decrease costs by providing guidance to the participants in the system regarding fair and reasonable reimbursements for acute inpatient hospital care. The fee guideline also should be adopted because of the facts discussed in this preamble which support the Commission's conclusion that the previous fee guideline rates should be revised.

The provisions of new §134.401 become effective on August 1, 1997 for all reasonable and medically necessary medical and/or surgical inpatient services rendered after that date to injured workers in an acute care hospital. This will allow a sufficient period of time for participants to make necessary changes in the billing process to implement the provisions of the new rule.

Beginning in early 1996, the TWCC Medical Advisory Committee (MAC) provided input regarding revision of the 1992 ACIHFG. The MAC, by statute (Texas Labor Code, §413.005), is to advise the Medical Review Division in developing and administering the medical policies, fee guidelines, and utilization guidelines established under the Texas Labor Code, §413.011. The MAC advises the Medical Review Division of the TWCC in the review and revision of medical policies and fee guidelines required under the Texas Labor Code, §413.012. The MAC is composed of representative members appointed by the Commission as follows: a representative of a public health care facility, a representative of a private health care facility, a doctor of medicine, a doctor of osteopathic medicine, a chiropractor, a dentist, a physical therapist, a pharmacist, a podiatrist, an occupational therapist, a medical equipment supplier, a registered nurse, a representative of employers, a representative of employees, and two representatives of the general public. In April of 1996 the MAC recommended to the Commission the proposal of the ACIHFG as eventually published in the July 26, 1996, *Texas Register* (21 TexReg 6939). That proposal was based on the same methodology (use of hospital contract rates) as in this adopted ACIHFG. This July 26, 1996, proposal was modified pursuant to information obtained from the TWCC Medical Advisory Committee, a Commission-appointed ACIHFG Task Force, and numerous public comments. In developing the rule proposal published here, the Commission utilized the information gathered during the development of the July 26, 1996 proposal and the information gathered following that proposal.

Following a public hearing on the proposed rule as published in the July 26, 1996 *Texas Register* (which was held on September 12, 1996), the Chairman of the Commission appointed an ACIHFG Task Force (the Task Force) as authorized by the Act, §413.006 composed of Charles Bailey, Texas Hospital Association; Becky Monroe, Houston Memorial Northwest Medical Center; Robert Kamm, Texas Association of Business and Chambers of Commerce; Pam Beachley, Business Insurance Consumers Association; and Todd Brown, Executive Director, TWCC. Anthony Heep of Spohn Memorial Hospital was added to the Task Force later. The Chairman appointed Todd Brown as Chair of the Task Force and directed Mr. Brown to establish the scope and objective of the Task Force. Mr. Brown asked the Task Force to examine the issues of tiered per diems for surgical admissions, exemption of certain items and/or services

from the per diem fees, and the stop loss threshold. The Task Force met on six occasions to exchange information and discuss the issues. After Plaintiffs THA et al. sued Mr. Brown in his individual, rather than official capacity, Robert Marquette, Director of the Medical Review Division, replaced Mr. Brown as the Chair of the Task Force. (See discussion of lawsuit elsewhere in this preamble.) The Commission staff took the ideas and information provided by the Task Force into consideration in developing its recommendation to the Commission. The Task Force was useful in presenting various views which were considered in establishing the ACIHFG and, for example, carve outs were incorporated due, in part, to Task Force input. However, there was no consensus in the Task Force on certain main aspects of reimbursement and the Commission believes there would be no further benefit in the creation of another Task Force because there was no indication of any ability of the different interest groups in reaching any consensus on basic areas of disagreement in the rate setting process within a reasonable time period. At the conclusion of the Task Force meetings on January 6, 1997, the members of the Task Force were invited to submit statements to the Commission regarding staff recommendations. The statements submitted illustrated the divergent views regarding the appropriate methods for determining fair and reasonable hospital reimbursements.

Public comment on the ACIHFG proposed in the July 26, 1996, issue of the *Texas Register* raised many issues including the carve out or exclusion of certain items and services from the guideline, changes in the stop-loss threshold, exemption of small/rural hospitals from the guideline, inclusion of outpatient services in the guideline, tiering of the surgical reimbursement rates, regional variation in reimbursement rates, and the effect of inflation on hospital reimbursement. Some commenters also questioned the validity of using managed care contracts as a basis for workers' compensation reimbursements, raising issues such as differences in case mix, differences in case complexity, and use of steerage in managed care contracts.

As a result of analysis of the information obtained by the Commission from these various sources and additional information gathered by the Commission staff, changes were made to the rule as proposed in the July 26, 1996 *Texas Register*. The knowledge which has been accumulated by the Commission since the July 26, 1996, proposal of the ACIHFG was used in formulating the second proposal (published on February 11, 1997).

Changes made to the February 11, 1997 proposal of the rule are in response to public comment received in writing and through public comment received at a public hearing held on March 6, 1997 and are described in the summary of comments and responses section of this preamble. Other changes were made for consistency or clarity. Commenters were invited to comment on all aspects of the rule, including, fee amounts, regional variations in fees, 100-bed or less hospital exemption, and tiered per diems, and were encouraged to submit data to support their positions. The changes from the rule as proposed do not affect any subject or person other than those subjects and persons included as potential or actual affected persons or subjects in the proposed rule preamble. The rule as proposed affected all regulated parties and subjects of regulation that are affected by the adopted rule. The public and affected persons were given sufficient advance notice of the rulepps content to permit them to ascertain whether protection of their interests required them to request a hearing and participate therein. The Commissioners exercised their discretion and judgment, experience, and expertise, to balance the statutory standards and the interests of all those affected.

This new rule will fulfill the requirements of the Texas Labor Code, §413.011 that the Commission by rule establish medical policies and guidelines, and the Texas Labor Code, §413.012 that the Commission periodically review and revise its fee guidelines. The new rule will revise provisions in the previous guideline including: increasing the per diem reimbursement for hospital services related to a medical admission from $600 to $870; increasing the per diem reimbursement for services related to a surgical admission from $1,100 to $1,118; decreasing the per diem reimbursement for intensive or cardiac care units services from $1,600 to $1,560; redefining the exemption for "small/rural" hospitals as an exemption for "hospitals which are located in a population center of less than 50,000 persons and have 100 or less licensed beds"; revising the basic reimbursement method to require the payment of the lesser of billed charges, contract rates or the per diem in the guideline; exempting from the per diem reimbursement provisions of the guideline certain high-cost services, supplies, and diagnoses in addition to MRIs, CAT scans and implantables; eliminating the requirement that an invoice be submitted for reimbursement of implantables; and lowering the stop-loss threshold to $40,000 and the stop-loss reimbursement factor to 75%.

Changes from the rule as proposed and published in the February 11, 1997 *Texas Register* are found in the following subsections of new §134.401: in subsection (a)(1) the effective date of the rule has been changed from June 1, 1997 to August 1, 1997, the sentence "Medical and/or surgical inpatient services rendered prior to the effective date of this rule shall be subject to the ACIHFG in effect at the time the services were rendered." has been deleted and the words "which are located in a population center of less than 50,000 persons and have" have been added to the last sentence; in subsection (b)(1)(B) the words "as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and" have been added; in subsections (b)(2)(D) and (c)(7)(A) the term "health care provider" has been changed to "health care practitioner" to provide consistency with the terms as defined in the Texas Labor Code; in subsection (c)(1) the per diem reimbursement for acute care inpatient surgical cases has been changed from $1,045 to $1,118; in subsection (c)(3)(C)(ii) the example has been recalculated using a surgical per diem rate of $1,118; in subsection (c)(4)(C) the word "charged" has been added to indicate that the $250 threshold is determined by charges and the sentence "Dose is the amount of a drug or other substance to be administered at one time" has been added to define the term "dose".

The effective date of the rule has been changed from June 1, 1997 to August 1, 1997 to provide a period of time after adoption of the rule for insurance carriers and acute care inpatient hospitals to make necessary changes to systems and procedures for implementation of the new ACIHFG. The sentence "Medical and/or surgical inpatient services rendered prior to the effective date of this rule shall be subject to the ACIHFG in effect

at the time the services were rendered." has been deleted from subsection (a)(1) in response to public comment (see specific response later in this preamble) to avoid confusion regarding the application of the previous ACIHFG (§134.400) to services rendered after that guideline was declared invalid by the courts. In that same subsection, the small hospital exemption has been changed by the addition of exemption criteria that the hospital be located in a population center of less than 50,000 persons. This addition means a hospital must be small (100 or less licensed beds in size) and be located in a population center of less than 50,000 people to be exempt from the provisions of the ACIHFG. In subsection (b)(1)(B) the language addition clarifies that the term "health care" is used as it is defined in the Texas Labor Code and that inpatient services as used in the rule refers to health care provided by an acute care hospital. In subsection (b)(2)(D) and (c)(7)(A) the term "health care provider" was changed to "health care practitioner" because, as these terms are defined in the Texas Labor Code, "health care practitioner" (an individual who is licensed to provide or render and provides or renders health care or a non-licensed individual who provides or renders health care under the direction or supervision of a doctor) expresses the meaning intended in these subsections. The Commissioners changed the per diem reimbursement for acute care inpatient surgical cases from $1,045 to $1,118 in subsection (c)(1) to ensure access to quality health care and as an additional protection to ensure fair and reasonable rates for surgical cases. The change takes into account the number of surgical cases as compared to medical cases in the workers' compensation system and inflation (see the detailed discussion of per diem rates chosen elsewhere in this preamble). The example in subsection (c)(3)(C)(ii) was recalculated to reflect the change in the surgical per diem rate. The changes to subsection (c)(4)(C) were made to clarify that the $250 threshold is determined by hospital charges and to define the term "dose". Although the term "durable medical equipment" is not contained in the rule as proposed or adopted, the terminology was inadvertently used in the draft preamble, but has been deleted in the adopted preamble and the more specific words "orthotics and prosthetics" substituted as appropriate.

The Commission considered all relevant statutory and policy standards and objectives and designed this new rule to achieve those standards and objectives, including the following:

(1) establish guidelines relating to fees charged or paid for medical services for employees who suffer compensable injuries, including guidelines relating to payment of fees for specific medical treatments or services;

(2) ensure that injured workers receive the health care reasonably required by the nature of their injury, as and when needed;

(3) ensure guidelines for medical services fees are fair and reasonable;

(4) design fee guidelines to ensure quality health care to the injured workers of Texas;

(5) design fee guidelines to achieve effective medical cost control;

(6) ensure guidelines for medical services fees do 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 someone acting on that individual's behalf;

(7) consider the increased security of payment afforded by the Act in establishing the fee guidelines;

(8) maintain a statewide database of medical charges, actual payments, and treatment protocols that may be used by the Commission in adopting medical fee guidelines;

(9) ensure the Commission's database contains information necessary to detect practices and patterns in medical charges and actual payments; and

(10) ensure the Commission's database can be used in a meaningful way to allow the Commission to control medical costs as provided by the Act.

This new rule achieves these standards and objectives by its provisions, including but not limited to the following:

(1) specifying the fees to be paid for acute care inpatient hospital services provided under the Texas Workers' Compensation Act;

(2) considering the amounts currently accepted by hospitals as payment in full under contracts for acute care inpatient services and for Medicare patients when setting the per diem rates, to avoid any adverse effect on the access to or quality of medical care, to ensure the per diem rates are fair and reasonable, to achieve effective medical cost control, and to ensure the workers' compensation rate is not in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living;

(3) requiring that payment to a hospital be the lesser of the amount specified in the fee guideline, the amount specified in a prenegotiated contract with the carrier, or billed charges to ensure that hospitals are not reimbursed for workers' compensation patients in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living, and to achieve effective medical cost control;

(4) including non-workers' compensation data in the data reviewed and utilized by the Commission to allow the Commission to detect practices and patterns in medical charges and actual payments,to determine fair and reasonable rates, to ensure access to quality medical care, to ensure that hospitals are not reimbursed for workers' compensation patients in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living, and to achieve effective cost control;

(5) considering the security of payment in the workers' compensation system resulting from the absence of co-payments and deductibles which are included in some managed care contracts, when setting rates and ensuring fees that are not in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living;

(6) providing for reimbursement to acute care hospitals which is sufficient to induce a sufficient number of hospitals to continue in the system to ensure access to quality medical care for injured workers in Texas; and

(7) exempting certain hospitals with 100 or less licensed beds in subsection (a)(1), lowering the stop-loss threshold, and including substantial carve outs from the per diem fees to ensure that reimbursement to hospitals is fair and reasonable and is sufficient to avoid any adverse effect on the access to or quality of medical care.

(8) adding approximately 7.0% additional to the average surgical rate found in the 1994-1995 per diem contracts to ensure access to quality health care and as an additional protection to ensure fair and reasonable rates for surgical cases while still achieving effective cost control.

These statutory and policy standards require the Commission to establish guidelines which balance the various interests in the workers' compensation system by ensuring that medical services fees are fair and reasonable, that injured workers receive quality health care, and that effective medical cost control is achieved. In addition to balancing these interests, and considering the increased security of payment in workers' compensation, the Texas Labor Code in §413.011 states that the Commission shall ensure guidelines for medical services fees do not provide for payment 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 someone acting on that individual's behalf. To comply with this statutory standard, the Commission, in reviewing and revising §134.400, sought to analyze the hospital reimbursements contained in that rule in relation to reimbursements hospitals were accepting from Medicare and under contracts as payment in full for persons of an equivalent standard of living outside the workers' compensation system for treatment similar to that provided to injured workers.

The Commission reviewed and analyzed a tremendous amount of data in determining the reimbursement rate set by this new rule for acute care inpatient hospital services, including the Commission's database of electronically filed bills and payments for the period October 1, 1994 through June 30, 1996 (representing over 12,000 hospital bills and in excess of 153 million dollars in hospital charges), 2564 managed care contracts or summaries of managed care contracts (from the hospitals receiving approximately 80% of the total workers' compensation reimbursement paid to hospitals in 1994 for acute care hospital inpatient services), analysis of Medicare rates, and state and federal agency information related to hospital health care. Contracts have been obtained from some of these same hospitals for the period October 1995 through October 1996. Public comments, public hearings, the Medical Advisory Committee, and a Commission-appointed Task Force provided extensive input that was thoroughly analyzed.

Texas acute care hospitals in 1995 received 33.3% of their gross patient revenue from third party payors and 40% from Medicare. Because these sources account for the vast majority of hospital patient revenue, the reimbursements paid by these payors is relevant to determining what fees are paid for similar treatment of persons of an equivalent standard of living, for establishing fair and reasonable fees, and for establishing fees at which hospitals will continue to provide quality health care while the Commission still achieves cost control. Voluntary participation in managed care contracts and in Medicare shows that reimbursements received from those payors are sufficient to cover the hospitals' costs.

The Commission obtained contracts or other agreements reflecting rates accepted as payment in full by Texas hospitals that were in effect for any dates of services on or after January 1, 1994 through October 1, 1995 (hereinafter referred to as "1994-1995 hospital contracts"). Per diem fees is the most commonly used (51.5%) method in the 1994-1995 hospital contracts, is the method used in the 1992 ACIHFG, and is administratively convenient. The 1994-1995 hospital per diem contracts set separate rates for medical services, surgical services, and intensive care unit services or for combined medical/surgical. The per diem 1994-1995 hospital contracts do not break the fees down into smaller segments of treatments and services, or into a larger number of categories. Rather, the one inclusive fee for each of the medical, surgical, and ICU categories of service in the 1994-1995 hospital contracts shows that it is appropriate to have one fee for medical, one fee for surgical, and one fee for ICU/CCU. The more recent managed care contracts reviewed by the Commission indicate that use of per diem rates is increasing in the industry. This shows that per diem rates established for what may be a broad category of services do result in fair and reasonable rates without different fees for smaller categories of services.

The per diem amounts in this rule for medical ($870), surgical ($1,118), and ICU/CCU ($1,560) services are the average of the per diem 1994-1995 hospital contracts for each category, with the addition of approximately 7.0% to the average surgical rate found in the 1994-1995 per diem contracts. This increase will provide additional reimbursement for those hospitals which experienced increases in payment from the rates contained in the 1994-1995 hospital contracts and summaries due to inflation. This increase is approximately 7.0% of the $1,045 rate and brings the surgical per diem rate to approximately 130% of the medical per diem rate of $870. This 130% difference between the surgical and medical per diem rates is equal to or greater than the corresponding differential in more than 80% of the managed care contracts obtained and considered by the Commission in setting the ACIHFG per diem rates. Just as the increases which result from the carve outs and the stop-loss provision, this increase in the surgical per diem rate will ensure injured workers' access to acute care inpatient services and serve as an additional protection to ensure fair and reasonable rates for surgical cases. Just as the increases which result from the carve outs and the stop-loss provision, this increase in the surgical per diem rate will ensure injured workers' access to acute care inpatient services and serve as an additional protection to ensure fair and reasonable rates for surgical cases. The Commission utilized its expertise and experience to increase the surgical rate from the amount in the proposed rule to achieve a proper balance of the statutory standards discussed elsewhere in this preamble. Other provisions in the rule serve to increase actual reimbursement, so this rule actually reimburses in excess of the contract averages. (See relevant discussions elsewhere in this preamble, including discussions regarding the exemption of certain small hospitals in subsection (a)(1), stop loss, outpatient services, case mix, inflation, and carve outs.) Alternate methods of reimbursement were considered by the Commission and rejected because they use hospital charges as their basis and allow the hospitals

to affect their reimbursement by inflating their charges, or are difficult to use because of the limited diagnosis groups applicable to workers' compensation cases and lack of data in billing.

The diagnostic-related groups (DRGs) method of reimbursement involves paying the hospital a predetermined fee based upon the patient's diagnosis rather than for example the length of stay or specific services provided. DRGs were not used as the methodology for this ACIHFG for several reasons. First, while Medicare utilizes DRGs, Medicare reimbursement rates for those DRGs are not based upon market-driven forces and largely involve non-working elderly patients who require longer lengths of stay and a higher percentage of co-morbidity. Second, the percentage of the managed care contracts utilizing DRG methodologies was 10.8% and, therefore, would not be as representative of the reimbursements as per diem contracts which comprised 51.5% of the managed care contracts. Third, only about five out of the approximately 494 DRGs used by other payors make up an estimated 60% of inpatient hospital workers± compensation cases. No data was received or could be located which would indicate how the workers± compensation cases within these five DRGs would be comparable to the typical Medicare cases in terms of complexity and intensity of care. Without such data, setting reimbursement rates within the statutory criteria would be extremely difficult, if not impossible. The per diem rate methodology plus the carve outs result in a more careful consideration of factors. In addition, the Commission has not received data from hospitals based upon DRGs because DRG designations are not reported on bills received by the Commission and no additional adequate data was received from commenters or other sources to assess the propriety of utilizing a DRG-type methodology.

The cost calculation on which cost-based models are derived, uses hospital charges as its basis. 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 107.0% from 1992 to 1996 and by 65% from 1993 through 1996, whereas for those 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 hospitalps costs of providing services nor of what is being paid by other payors. Therefore, under a so-called cost based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory mandate of achieving effective medical cost control and the mandate not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs.

In recognition of the type of cases which may occur more frequently in workers' compensation than in other systems, the ACIHFG carves out the majority of the highest cost cases (eg. trauma and burns) from the per diem reimbursement amount and provides stop-loss reimbursement for cases with total audited charges which exceed $40,000. This should compensate for any alleged additional reimbursement due for cases requiring a high level of services

All carved out items and services ("carve outs") that are in any of the 1994-1995 hospital contracts (even those in less than 1.0%) and are applicable to typical workers' compensation cases are included as carve outs in this rule and increase reimbursement. The carve-outs are based on the 1994-1995 hospital contracts. Other provisions which serve to increase reimbursement include a stop loss provision, the threshold for which and the percentage reimbursement for which was determined from the 1994-1995 hospital contracts, and the addition of approximately 7.0% to the average surgical rate found in the 1994-1995 per diem contracts.

The rule exempts from its provisions hospitals with 100 beds or less which are located in a population center of less than 50,000. With the exception of several small hospitals (each in population centers of 50,000 or more people) in the list of hospitals receiving the top 80% of workers' compensation reimbursement in 1994, contracts were not requested from hospitals which included the remaining 20% of workers' compensation reimbursement due to the small number of workers' compensation cases handled by such hospitals. The hospitals which received the top 80% of workers' compensation reimbursement did not include hospitals in population centers of less than 50,000 people. The Commission had insufficient data regarding the differing circumstances of hospitals in population centers of less than 50,000 people and the effect of these circumstances on the costs and payment rates of such hospitals. The Commissioners wished to protect and preserve the access to local hospitals for an injured worker who lives or works in a population center of less than 50,000 people. In addition, the Commissioners sought to avoid encouraging hospitals in population centers of 50,000 or more people to reorganize into smaller entities to seek exemption from the per diem reimbursements in the ACIHFG based upon the 100 or less licensed beds exemption. Finally, while hospital payment data was utilized to determine average payments and to reflect competition in the hospital marketplace in population centers of 50,000 or more people, such data was not obtained for population centers of less than 50,000 people.

Commenters opposing use of managed care contracts as a basis for workers' compensation reimbursements allege that payments for workers' compensation patients should be higher than managed care rates because of differences in case complexity, case mix and length of stay. During the meeting of the ACIHFG Task Force, information was provided that indicated hospitals consider utilization when negotiating contract terms, and, as a result, utilization has already been accounted for in the contract rates. An actuarial study, described in detail elsewhere in this preamble, using two methods, including one that adjusted for typical length of stay, shows that workers' compensation cases are not more complex than managed care cases. Commission data shows that over 80% of possible emergency room inpatient admissions will be reimbursed at a fair and reasonable rate rather than the per diem rate, because of the carve outs in the rule. If any additional reimbursement is appropriate for any of the alleged reasons, the extensive carve outs,

increase in the surgical per diem rate, and other items of the rule that increase reimbursement would compensate. Information received from the Texas Hospital Association in response to the Commission's 1994 Request for Information stated that it was unaware of any adverse impact on access to care as a result of the 1992 per diem rates, and the Commission has no data or information which would indicate that a hospital(s) has refused to treat workers' compensation patients because of the fees provided in the 1992 ACIHFG. Therefore, there should be no decrease in access to care for injured workers under this new rule. The per diem fees in this rule are higher than the workers' compensation reimbursements voluntarily contracted for by the hospitals which contracted for workers' compensation in their managed care contracts, and other provisions of the rule serve to increase reimbursement above the amount stated as the per diem rate. Testimony by hospital representatives at the public hearing on the previous proposal of this rule revealed that generally hospitals do not knowingly negotiate contract rates where the hospitals lose money in providing a specific service.

Because very few of the 1994-1995 hospital contracts contain steerage guarantees or exclusivity clauses, and because of statutory standards, these issues were not addressed in this rule. Additionally, workersb compensation does not rely on co-payments or deductibles which are key components in managed care. The absence of the necessity to collect such co-payments or deductibles increases the security of payments in the workers' compensation system which would argue for setting workers' compensation rates lower than managed care rates. The Commission has, however, chosen not to do so because the quantifiable effect of the security of payment on rates is unclear. In addition, 'steerage' of patients to a particular hospital has markedly decreased as an important factor in the determination of hospital contract rates as managed care contracts are updated. Typically managed care organizations contract with every hospital in an area. In the current market hospitals are rarely given an exclusive contract because most hospitals cannot offer all the services necessary, most contracts do not guarantee a particular level of patient days or business, and contracting with a particular plan is increasingly driven by the fact that a hospital does not want to be excluded as one of the provider hospitals in a plan rather than any probable increase in the number of patients.

The Commission cannot at this time confirm or dispute the contention that the costs of outpatient services are different when provided in a hospital. Because reimbursement for typical outpatient services at the TWCC Medical Fee Guideline rates could affect access to services and quality of care for injured workers, outpatient services will be reimbursed at fair and reasonable rates for hospitals. This will ensure access to quality health care for injured workers by ensuring that hospitals will continue to provide outpatient services to workers' compensation patients. Outpatient emergency services are not subject to this guideline. However, emergency room services associated with a hospital inpatient admission are subject to the guideline. Emergency professional services are not subject to this ACIHFG and are reimbursed in accordance with the Medical Fee Guideline in effect at the time the services are provided. Emergency transportation, other than air ambulance, will continue to be reimbursed in accordance with the TWCC Medical Fee Guideline in effect at the time the services are rendered.

Tiered surgical rates are not necessary for a rate to be fair and reasonable, or to ensure access to quality health care. Tiering of per diem rates was not the predominant method of utilizing per diem reimbursements; only 7.0% of the 1994-1995 hospital per diem contracts contained some form of tiered per diem for surgical admissions. Therefore, consideration of front loaded expense and severity must have been factors in negotiating the contract rates; to the extent they were not, other provisions in this rule will compensate, as they serve to increase actual reimbursement. Because the average length of stay for surgical cases has declined on the average to be similar to surgical lengths of stay for managed care contracts, there was no need for a tiered per diem as a device to limit the lengths of stay.

Regional rate variation is not necessary for a rate to be fair and reasonable, or to ensure access to quality health care. There is no correlation, and in some regions a negative correlation, between the areas with higher labor costs and those with the higher per diem contract rates. Commission analysis of the contracts entered into by hospitals within the same chain of hospitals reveals no consistency by hospital, by metropolitan statistical area (MSA), or by carrier. There is also no correlation between hospital type or hospital bed size. Differences which may be attributable to hospital and community size have been recognized and accounted for by the exemption for hospitals with 100 or less licensed beds in population centers of less than 50,000 people from the per diem reimbursement rates in the new ACIHFG. Differences in levels of care provided by some hospitals have been recognized and accounted for by the carve outs. Averaging minimizes the effect of outliers in the data because most rates were closer to the average than to either the higher or lower rates, because the lowest rates may not accurately reflect hospital economic factors for all the hospitals with greater rates and because a reimbursement based on an average rate will be a greater incentive for maintaining access to quality health care than use of the lowest rates.

A rise in the Medical Care Services (MCS) CPI does not necessarily indicate that hospitals should receive greater reimbursements and the Commission did not directly use it to determine hospital reimbursement rates. However, when compared to inflation, the fees in this rule are sufficient to account for the inflation of 12% reflected in the CPI for the period from 1993 to 1996, and the estimated 17.4% increase over previous rates (which percentage does not account for any possible increased reimbursement due to the exemption of small hospitals located in population centers of less than 50,000 persons) is just under the MCS CPI of 18% for the period 1993 to 1996.

Preliminary analysis of the contracts for the period October 1995 through October 1996 shows little or no change in the average per diem reimbursement rates and shows that the total number of contracts that have per diem rates is increasing. 52.6% of the hospitals have more per diem contracts than before and 84.96% of the per diem rates for the same hospital were either reduced, stayed the same, or increased by less than 10%. Action by the federal advisory panel on Medicare, and a report on hospital performance for the past five years reinforce the Commission's conclusion regarding adjustments for inflation.

The Commission also compared the per diem rates derived from the 1994-1995 hospital contracts to Medicare rates. Studies show that Medicare patients are of an equivalent standard of

living to workers' compensation patients. The studies were performed by Research and Planning Consultants, Inc. and by Dr. Ronald T. Luke, Ph.D. J.D. who provide economic and public policy analyses to numerous public and private sector clients in health care matters including managed care organizations and who provide health cost management services with special attention to workersp compensation medical care cost. The most recent study noted that managed care has become the dominant form of health care coverage for U.S. workers. That study, also, noted that many low skilled and low paying jobs do not carry health insurance benefits and, therefore, workers covered by managed care plans have an equal or higher living standard than workers in general. The study utilized extensive health care literature and information. An actuarial study, described in detail elsewhere in this preamble, adjusted for length of stay, calculated the estimated Medicare per diem rates for the five Diagnostic Related Groups (DRG's) that would account for 60% of workers' compensation inpatient hospital payments if a DRG system were in place. This study concludes that for these five DRG's, hospitals will receive higher reimbursement for workers' compensation patients than they do for Medicare patients. This reinforces the Commission's conclusion that the per diem rates from the 1994-1995 hospital contracts are fair and reasonable, will ensure access to quality medical care, will achieve effective cost control, and will not pay in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living.

Some comparisons between managed care and workers' compensation may support an argument that the workers' compensation rate should be a reduction from the managed care rates. Comparisons consider the fact that workers' compensation cases are less complex than managed care cases, the inclusion of carve outs in this rule that are carved out in very few of the 1994-1995 hospital contracts, the lowering of the stop loss threshold even though hospital charges have been inflated, the exemption of small hospitals located in a population center of less than 50,000 people, and increased security of payment in workers' compensation. The Commission believes that these are all factors that should be watched and analyzed as experience with any new rule is gained. Data, information, and input will be obtained and reviewed, and action taken to adjust the fees and other aspects of the rule as appropriate.

The Commission is faced with the difficult task of meeting numerous, often seemingly contradictory, statutory standards and objectives. The legislature called for the Commission to balance the statutory standards and the interests of all those affected. This necessarily involves the exercise of the Commission's discretion and judgment which rests in part on the agency's experience and expertise. After thorough analysis of alternatives and all data and information the Commission has or which was submitted to the Commission, the Commission determined what data would be relevant and how to secure reliable data, secured that data, analyzed the data, examined it again to determine if it was indeed reliable and relevant, received and analyzed all input from affected persons, and considered alternatives. The result of the Commission's full and objective analysis is the rule adopted by this Commission order. As described and explained in more detail throughout this preamble, based upon a review of the applicable factual, legal, and policy concerns, the Commission concludes that this rule meets all statutory standards and objectives and is the appropriate and rational response to those standards and objectives and to the facts and data before the Commission.

In developing this new rule, the Commission utilized its database of workers' compensation hospital charges and payments. This database contains reliable information submitted electronically by hospitals on UB92 reporting forms. Information from this database for the period October 1, 1994 through June 30, 1996 was used. This data represents over 12,000 hospital bills and in excess of 153 million dollars in hospital charges. This Commission data was useful in determining the average length of stay for hospitalized workers' compensation patients, types of cases which utilize hospital services in the workers' compensation system, the amount of reimbursement hospitals receive under the workers' compensation system and substantial and non-uniform differences between hospital charges and what is being accepted by hospitals as payment for the same or similar services. Although this Commission data was useful in these respects, it was determined that additional data would be useful in determining fair and reasonable reimbursements for acute care inpatient hospital services in workers' compensation, ensuring access to quality health care, and in obtaining information relevant to effective cost control and to the statutory standard of fees not in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living. The consideration and analysis of these statutory factors with regard to various types of data is described later in this preamble.

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 during the years 1994 through 1996, hospital charges for surgical cases significantly increased while charges for medical cases have remained approximately the same based upon the Commission's data base of workers' compensation hospital charges for those years. Charges for ICU cases could not be analyzed because the Commission's data on such charges were not segregated from surgical and medical case bills. Charges for surgical hospital admissions increased by 107.0% from 1992 through 1996 and by 65% from 1993 through 1996, whereas for those 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. The hospital payment data contained in the Commission's database, for the most part, simply reflects the reimbursement schedule contained in previous rule §134.400 and does not provide information regarding the current payments accepted in the largest segments of the marketplace for hospital services.

An additional source of information on hospitals was the Texas Department of Health, Bureau of State Health Data and Policy Analysis Annual Survey of Hospitals which provides aggregate financial information, utilization and other data from all licensed hospitals in Texas. This information was useful in determining the bed-size of hospitals in Texas and revenue sources of Texas hospitals e.g. Medicare, managed care.

In order to determine what reimbursements were being paid to hospitals outside the workers' compensation system, the Commission sought a source of accurate, verifiable data. The Texas Department of Health, Bureau of State Health Data and Policy Analysis' 1996 report from its annual survey of hospitals, revealed that in 1995 Texas acute care hospitals received 40% of their gross patient revenue from Medicare, and 33.3% from third party payors. Because these sources account for the vast majority of hospital patient revenue, the reimbursements paid by these payors is a relevant basis for comparison between workers' compensation reimbursements and these other major reimbursement systems for similar hospital services for persons of an equivalent standard of living, and for establishing fair and reasonable fees for workers' compensation. The fact that hospitals on average receive over 70% of their gross patient revenue from choosing to participate in Medicare and managed care, indicates that reimbursements received from those payors are sufficient to cover the hospitals' costs. Workers' compensation inpatient hospital payments constitute less than 1.0% of total inpatient hospital business. (See also, relevant discussions regarding managed care contract data, Medicare rates comparison, case complexity, and data used in studies performed by Milliman and Robertson.)

Prior to the enactment of the current workers' compensation law, the legislative Joint Select Committee on Workers' Compensation undertook an extensive study of the existing Texas workers' compensation law. In its report to the 71st Legislature, the Committee found that workers' compensation medical costs were high in relation to those in other states and had increased faster than medical costs outside the system and faster than indemnity costs. (*Joint Select Committee on Workers' Compensation Insurance, A Report to the 71st Texas Legislature*, p. 3).

To address this problem, the legislature included provisions in the new Texas Workers' Compensation Act which make clear its intent that the Commission consider fees paid for health care services outside the workers' compensation system when adopting fee guidelines. These statutory provisions, in turn, demonstrate the relevance of the managed care contracts to the hospital fee guideline rulemaking proceeding. Consideration of managed care contract fees addresses the policy that workers' compensation should no longer be subsidizing the provision of non-workers' compensation medical care, including that which is subject to managed care. (*Research Papers of the Joint Select Committee* (September 1988, Chapter 6)).

The relevance of the managed care contracts to the hospital fee guideline rulemaking proceeding is further demonstrated by the Texas Department of Health's 1995 report, *Reporting and Collection Systems for Texas Hospitals, 1996*. As noted elsewhere in this preamble, the report shows that 40% of gross patient revenue for Texas hospitals came from Medicare and 33.3% came from third party payors, including payments made pursuant to managed care contracts. Because third party payors are the second largest payor group in terms of gross patient revenue, the amounts paid to hospitals by third party payors are relevant to determining fair and reasonable workers' compensation reimbursements to hospitals. This is particularly true because the payments are made pursuant to managed care contracts which the hospitals voluntarily entered into.

More specifically, Texas Labor Code §413.011, which provides that the Commission establish fee guidelines, specifies that those guidelines may not provide for payment of a fee in excess of the fee charged and paid for similar treatment of an injured individual of an equivalent standard of living or by someone acting on that individual's behalf. To comply with this legislative standard, the Commission reviewed the payments made for health care services outside the workers' compensation system. The managed care contracts are directly relevant to the hospital fee guideline rulemaking proceeding.

Managed care contracts are relevant to what fair and reasonable reimbursement (§413.011(b)) is - they are a market price negotiated voluntarily. They show rates a business (a hospital), which voluntarily accepts patients, is willing to accept for provision of services.

Managed care contracts are relevant to achieving cost control (§413.011(b)) because they are the lowest rates negotiated for the working age population, which is also the population of workers' compensation injured workers.

Managed care contracts are relevant to ensuring access to quality care (§413.011(b)), because as voluntarily negotiated rates, they reflect rates at which a hospital will continue to take patients.

Managed care contracts are relevant to the statewide database (§413.007) the Commission is required to maintain: a database of charges, actual payments, and treatment protocols that is sufficient to detect practices and patterns in charges and payments and can be used in a meaningful way to control costs.

The managed care contract information is highly reliable; it was obtained directly from the hospitals. Either copies of the actual contracts were provided or certified summaries of information from the contracts were provided by the hospitals.

A commenter suggested that using the managed care contracts for setting per diem rates in the ACIHFG is inconsistent with the reasoning used in the development of the Medical Fee Guideline (MFG). The MFG establishes maximum allowable reimbursements for services provided by health care providers. Managed care contract reimbursement rates for primary care health care providers often are based on a capitation type reimbursement method which usually does not provide specific amounts for specific services. In addition, unlike acute care inpatient hospital reimbursement data, the data utilized for the MFG (§134.201) did not reveal that Medicare plus managed care reimbursements constituted a majority of total reimbursements for non-workers' compensation cases. Because of this, data from managed care contracts with health care providers was not utilized for development of §134.201 (MFG). Instead, fee for service data was utilized as the basis for deriving the maximum allowable reimbursement amounts for the MFG (§134.201). On the other hand, as described in detail previously in this preamble, managed care contracts with hospitals were determined to be the best indication of a market price voluntarily negotiated for hospital services. The development of fee guidelines which comply with statutory mandates requires the careful analysis of available data and reimbursement op-

tions for the services to be covered by the guideline. The same methodology may not be appropriate for every guideline.

During the meeting of the ACIHFG Task Force information was provided that indicated hospitals consider utilization when negotiating contract terms, as a result, utilization has already been accounted for in the contract rates.

To gather data regarding the amounts being accepted from third party payors as payment in full for acute care inpatient hospital services in Texas, the Commission ordered and obtained from hospitals copies of contracts or summaries of contracts reflecting rates accepted by selected Texas hospitals as payment in full from third party payors, including managed care organizations, for inpatient hospital services, both workers' compensation and non-workers' compensation.

To determine which hospitals would be required to provide contract information, the Commission's database was used to rank hospitals by the dollar amount of reimbursement each hospital received for workers' compensation cases for calendar year 1994. The year 1994 was chosen because it was the most recent full year of data available at the time the ranking was done. After ranking the hospitals, it was determined that the top 80 hospitals received approximately 80% of the total workers' compensation reimbursement paid to hospitals in 1994 for acute care hospital inpatient services. None of the hospitals which received the remaining 20% of the total 1994 hospital reimbursement for acute care inpatient services were reimbursed a significant portion of the total workers' compensation reimbursement for such services. As a result, the Commission determined that obtaining contracts from the top 80 hospitals would provide relevant information to determine fair and reasonable rates, access to quality health care, cost control, and payments for similar treatments of persons of an equivalent standard of living.

The Commission sent letters to these 80 hospitals requesting copies of all contracts or other agreements reflecting rates accepted as payment in full by each hospital that were in effect for any dates of services on or after January 1, 1994 through October 1, 1995 (1994-1995 hospital contracts). Almost all of the hospitals refused to voluntarily produce the contracts and, as a result, the Commission issued orders on January 26, 1996 requiring the production of the 1994- 95 hospital contracts. The Texas Hospital Association, as well as almost all of the hospitals from whom contracts were sought filed suit. The parties reached an agreement for issuance of a permanent protective order which prohibits the Commission from disclosing these contracts and summaries and certain information in those contracts and summaries (generally described as certain hospital identifying information related to those contracts and summaries).

Because of mergers, acquisitions, corporate buyouts and other similar ownership changes, all of the 80 hospitals originally identified did not individually respond to the Commission orders. However, none of the hospitals ordered to produce contracts reported that they had no such contracts. The hospitals producing contracts were located throughout the state. With the exception of one, all of the following hospitals producing contracts are 100 or more licensed beds in size, ranging in size from 118 beds to over 900 beds.

TOP 80 HOSPITALS (Calendar Year 1994, Sorted Alphabetically):

All Saints Episcopal Hospital, Fort Worth
AMI Twelve Oaks Hospital, Houston
AMI Park Plaza Hospital, Houston
Arlington Memorial Hospital, Arlington
Baptist Memorial Hospital System San Antonio
Baptist Hospital of Southeast Texas, Beaumont
Baylor University Medical Center, Dallas
Bethania Regional Health Care Center, Wichita Falls
Bexar County Hospital District, San Antonio
Brackenridge Hospital, Austin
Brownsville Medical Center, Brownsville
Citizens Medical Center, Victoria
Cypress Fairbanks Medical Center Hospital, Houston
Doctors Hospital East Loop, Houston
Garland Community Hospital, Garland
Good Shepard Medical Center, Longview
Harris Methodist-Fort Worth, Fort Worth
Harris Methodist H E B, Bedford
HCA Medical Center Hospital, Houston
HCA Medical Plaza Hospital, Ft Worth
HCA North Hills Medical Center, North Richland Hills
HCA West Houston Medical Center, Houston
HCA Medical Center-Plano, Plano
HCX South Arlington Medical Center, Arlington
Hendrick Medical Center, Abilene
Hermann Hospital, Houston
High Plains Baptist Hospital, Amarillo
Hillcrest Baptist Medical Center, Waco
Houston NW Medical Center, Houston
Humana Hospital-Clear Lake, Webster
Humana Hospital Metro, San Antonio
Humana Hospital-San Antonio, San Antonio
Humana Hospital Medical City-Dallas, Dallas
McAllen Medical Center, Mc Allen
Medical Arts Hospital, Dallas
Medical Center Hospital, Tyler
Medical Center Hospital, Odessa
Memorial City Medical Center, Houston
Memorial Medical Center, Corpus Christi

Memorial Hospital System, Houston

Methodist Hospital Lubbock, Lubbock

Methodist Medical Center, Dallas

Midland Memorial Hospital, Midland

Mother Frances Hospital Regional Healthcare Center, Tyler

Nix Medical Center, San Antonio

Northeast Medical Center Hospital, Humble

Northwest Texas Hospital, Amarillo

Osteopathic Medical Center of Texas, Fort Worth

Park Place Hospital, Port Arthur

Parkland Memorial Hospital, Dallas

Presbyterian Hospital, Dallas

Providence Memorial Hospital, El Paso

RHD Memorial Medical Center, Dallas

Rio Grande Regional Hospital, Mc Allen

Rosewood Medical Center, Houston

Santa Rosa Hospital, San Antonio

Scott and White Memorial Hospital, Temple

Seton Medical Center, Austin

Shannon West Texas Memorial Hospital, San Angelo

Sierra Medical Center, El Paso

Southwest Texas Methodist Hospital, San Antonio

Spohn Hospital, Corpus Christi

St. Joseph Hospital of Houston, Houston

St. Lukes Episcopal Hospital, Houston

St. Davids Community Hospital, Austin

St. Joseph Hospital, Fort Worth

St. Elizabeth Hospital, Beaumont

St. Anthonys Hospital, Amarillo

St. Lukes Lutheran Hospital, San Antonio

Sun Belt Regional Medical Center, Houston

Sun Towers Hospital, El Paso

The Methodist Hospital, Houston

University Medical Center, Lubbock

University of Texas-Medical Center, Galveston

Valley Baptist Medical Center, Harlingen

Vista Hills Medical Center, El Paso

Westbury Hospital, Houston

Zale Lipshy University Hospital, Dallas

Two of these hospitals had closed and did not submit contracts or summaries of contract information. A total of 2,564 contracts or summaries of contracts were received. Of these, 1,320 were actual contract documents and 1,244 were detailed summaries, prepared by the hospitals, of information from contracts.

For the calendar year 1995 the Commission has identified Texas hospitals which received approximately 80% of the total workers' compensation reimbursement paid to hospitals in that year for acute care inpatient hospital services. The Commission on November 13, 1996, sent letters to these hospitals requesting copies of all their contracts or other agreements (or certified summaries) reflecting rates accepted as payment in full for acute care inpatient hospital services, that were in effect for any dates of services on or after October 2, 1995 through October 1, 1996. In addition, the Commission requested copies of contracts from hospitals which were on the list of top 80 hospitals for the calendar year 1994 but were not on the list for 1995. The Commission has performed some preliminary analysis of these contracts, and will continue to analyze them.

The Commission does not believe that the fluctuation in the number of hospitals in the top 80% indicates a decline in the number of hospitals accepting workers' compensation cases. The Commission has no data or information that any injured worker has been denied access to hospital care and has seen no trend in this direction. The fluctuation between the number of hospitals receiving 80% of workers' compensation reimbursement is attributed to normal, expected fluctuation in cases from one year to another. This fluctuation is insignificant because for example, the difference in reimbursement received by a hospital ranked 80 and a hospital ranked 81 is so small that one additional admission that amounts to a few thousand dollars may be enough to change the hospitalsþ ranking and potentially reduce the number of hospitals that represent the top 80% of total workersþ compensation reimbursement. Change in the number of hospitals in the top 80% does not indicate hospitals are not accepting workersþ compensation cases.

HOSPITALS RECEIVING TOP 80% OF TOTAL REIMBURSEMENT FOR WORKERS' COMPENSATION ACUTE INPATIENT HOSPITAL CARE (Calendar Year 1995, Sorted Alphabetically):

All Saints Episcopal Hospital, Fort Worth

AMI Twelve Oaks Hospital, Houston

AMI Park Plaza Hospital, Houston

Arlington Memorial Hospital, Arlington

Baptist Memorial Hospital System, San Antonio

Baylor University Medical Center, Dallas

Bayshore Medical Center, Pasadena

Bethania Regional Health Care Center, Wichita Falls

Brackenridge Hospital, Austin

Brownsville Medical Center, Brownsville

Clear Lake Regional Medical Center, Webster

Columbia Bay Area Medical Center, Corpus Christi

Columbia Medical Center West, El Paso

Columbia Medical Center East, El Paso
Conroe Regional Medical Center, Conroe
Doctors Regional Medical Center, Corpus Christi
Doctors Hospital East Loop, Houston
East TX Medical Center, Tyler
Garland Community Hospital, Garland
Good Shepherd Medical Center, Longview
Harris County Hospital District, Houston
Harris Methodist H E B, Bedford
Harris Methodist-Fort Worth, Fort Worth
HCA Arlington Medical Center, Arlington
Healthsouth Medical Center, Dallas
Healthsouth Rehab Institute of San Antonio, San Antonio
Hendrick Medical Center, Abilene
Hermann Hospital, Houston
High Plains Baptist Hospital, Amarillo
Hillcrest Baptist Medical Center, Waco
Houston NW Medical Center, West Houston
John Peter Smith Hospital, Fort Worth
McAllen Medical Center, McAllen
Medical Center Hospital, Odessa
Medical Center of Plano, Plano
Medical Arts Hospital, Dallas
Memorial Hospital and Medical Center, Midland
Memorial Hospital Memorial City, Houston
Memorial Health Care, Houston
Memorial Medical Center, Corpus Christi
Mercy Regional Medical Center, Laredo
Methodist Medical Center, Dallas
Methodist Hospital Lubbock, Lubbock
Metropolitan Hospital, San Antonio
Mother Frances Hospital Regional Healthcare Center, Tyler
Northwest TX Health Care System, Amarillo
Osteopathic Medical Center of TX, Fort Worth
Park Place Hospital, Port Arthur
Parkland Memorial Hospital, Dallas
Plaza Medical Center, Fort Worth
Presbyterian Hospital, Dallas
Presbyterian Hospital of Plano, Plano
Providence Health Center, Waco
R E. Thomason General Hospital, El Paso
RHD Memorial Medical Center, Dallas
Rio Grande Regional Hospital, McAllen
Rosewood Medical Center, Houston
San Antonio Regional Hospital, San Antonio
San Jacinto Methodist Hospital, Baytown
Santa Rosa Health Care Corporation, San Antonio
Scott and White Memorial Hospital, Temple
Seton Medical Center, Austin
Shannon Medical Center, San Angelo
Sierra Medical Center, El Paso
Southwest TX Methodist Hospital, San Antonio
Spohn Health System, Corpus Christi
Spring Branch Medical Center, Houston
St Joseph Regional Medical Center, Bryan
St. Davids Rehab Center, Austin
St. Mary Hospital of Port Arthur, Port Arthur
St. Joseph Hospital of Houston, Houston
St. Mary of the Plains Hospital & Rehab Center, Lubbock
St. Paul Medical Center, Dallas
St. Lukes Episcopal Hospital, Houston
St. Elizabeth Hospital, Beaumont
St. Davids Community Hospital, Austin
St. Anthonys Hospital, Amarillo
Sun Belt Regional Medical Center, Houston
Texas Orthopedic Hospital, Houston
The Methodist Hospital, Houston
University Health Care System, San Antonio
University of TX-Medical Branch, Galveston
University Medical Center, Lubbock
Victoria Regional Medical Center, Victoria
Wadley Regional Medical Center, Texarkana
West Houston Medical Center, Houston
Wichita General Hospital, Wichita Falls
Zale Lipshy University Hospital, Dallas

HOSPITALS WHICH WERE INCLUDED IN THE TOP 80 HOSPITALS FOR CALENDAR YEAR 1994, BUT NOT INCLUDED IN TOP 80% FOR CALENDAR YEAR 1995 (Sorted Alphabetically):

Baptist Health Care System, Beaumont
Citizens Medical Center, Victoria
Cypress Fairbanks Medical Center Hospital, Houston
HCA North Hills Medical Center, North Richland Hills

Nix Medical Center, San Antonio

Northeast Medical Center Hospital, Humble

Providence Memorial Hospital, El Paso

St. Lukes Baptist Hospital, San Antonio

Valley Baptist Medical Center, Harlingen

In reviewing §134.400, the previous Acute Care Inpatient Hospital Fee Guideline, the Commission considered alternate methods of reimbursement for acute care inpatient hospital services. Cost-based methods of reimbursement which estimate the cost of treating a case by multiplying the hospital charges by the cost-to-charge ratio (obtained by dividing the hospital's total reported expenses by total reported revenue for the same period) were considered. To determine the reimbursement for a particular service, the billed charge is multiplied by the cost- to-charge ratio for that hospital. This method seeks to produce reimbursements which take into consideration the hospital's cost to deliver the service.

The Commission chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models (including that submitted by the Texas Hospital Association) are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs. This is exemplified by the substantial and non-uniform differences between these charges and what is being accepted by hospitals as payment, and by the 107.0% increase in surgical hospital admission charges in the same time period in which the CPI inflation rate was 16% and the MCS of the CPI inflation rate was 29%. Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost- based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs. In addition, setting individual ratios or negotiating with each hospital would be administratively burdensome for the Commission and for workers' compensation system participants and would require additional Commission resources.

A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

Prospective payment methods, in addition to the per diem method ultimately chosen, were considered. Prospective payment amounts can be determined by using diagnostic-related groups (DRGs). The DRG method of reimbursement involves paying the hospital a predetermined fee based upon the patient's diagnosis rather than, for example, the length of stay or specific services provided. DRGs were not used as the methodology for this ACIHFG for several reasons. First, while Medicare utilizes DRGs, Medicare reimbursement rates for those DRGs are not based upon market-driven forces and largely involve non-working elderly patients who require longer lengths of stay and a higher percentage of co-morbidity. Second, the percentage of the managed care contracts utilizing DRG methodologies was 10.8% and, therefore, would not be as representative of the reimbursements as per diem contracts which comprised 51.5% of the managed care contracts. Third, only about five out of the approximately 494 DRGs used by other payors make up an estimated 60% of inpatient hospital workersþ compensation cases. No data was received or could be located which would indicate how the workersþ compensation cases within these 5 DRGs would be comparable to the typical Medicare cases in terms of complexity and intensity of care. Without such data, setting reimbursement rates within the statutory standards would be extremely difficult, if not impossible. The per diem rate methodology plus the carve outs result in a more careful consideration of standards. In addition, the Commission has not received data from hospitals based upon DRGs because DRG designations are not reported on bills received by the Commission and no additional adequate data was received from commenters or other sources to assess the propriety of utilizing a DRG- type methodology. The Commission has insufficient data at this time to determine whether use of DRG weights with a per diem system would be feasible or appropriate, especially given probable differences in complexity of case questions in the Medicare population where DRG reimbursement is used.

The Commission notes that hospitals have sued to invalidate each and every hospital fee guideline adopted by the Industrial Accident Board or the Commission. These have included challenges to a cost-based ratio rule, a DRG rule and a per diem rule.

After careful analysis of relevance (discussed elsewhere in this preamble) regarding the use of the hospital contracts in determining a guideline for fair and reasonable workers' compensation inpatient hospital reimbursements, the Commission concluded that the hospital contracts provided the most accurate, verifiable information of the current hospital service market and thus the most relevant information regarding fair and reasonable rates, access to quality health care, cost control, and fees paid for similar treatment by persons of an equivalent standard of living. Hospitals are voluntarily participating at these negotiated rates for what constitutes 33.3% of their gross revenue. In addition, testimony at the public hearing on the previous proposal of this rule by hospital representatives revealed that generally hospitals do not knowingly negotiate contract rates where hospitals lose money.

The 1994-1995 hospital contracts and contract summaries were analyzed by comparing the rates for medical services, surgical services, and intensive care unit services in each contract. Data on approximately 2,564 contracts was received and analyzed. Of these 2,564 contracts, approximately 10.8% based fees on diagnostic related groups (DRGs); approximately 30.5% based fees on a discount from charge; approximately 51.5% based fees on a per diem rate; and approximately 7.2% based fees on some other method (such as capitation, case by case, or some combination of methods).

Some of the 1994-1995 hospital contracts included hospital rates for workers' compensation cases and approximately 1.3% of the contracts were for workers' compensation cases only. The average workers' compensation per diem rate in the 1994-1995 hospital contracts was $610 for medical cases, $1,030 for surgery cases, and $1,514 for ICU cases. The commenters assertion that the discount from the previous TWCC fee schedule applies to a limited patient population is incorrect in that these discounts apply to all workersþ compensation patients. Workersþ compensation patients have access to all hospital services and utilization is not limited.

The per diem method was chosen for new §134.401 because (as discussed elsewhere in this preamble) the per diem method of reimbursement was the most commonly used (51.5%) method for inpatient hospital reimbursement in the 1994-1995 hospital contracts, because of the disadvantages of other payment methods (described elsewhere in this preamble), because this is the method used in previous rule §134.400 for workers' compensation inpatient hospital reimbursement and therefore allows greater continuity in administrative billing procedures, and because the per diem method has advantages in administrative convenience in billing and reviewing of bills. Although initial administrative set up costs for this guideline will be necessary for both insurance carriers and hospitals, carve outs should not significantly impact the administrative costs to the system. The Commission expects that most of the information necessary to determine reimbursement for carve outs will come directly from the UB-92 form because ICD-9 codes which cover the trauma, burn, and HIV carve outs, are listed directly on the UB-92. Revenue codes are also directly listed on the UB-92 for MRI, CAT scans, hyperbaric oxygen, blood and air ambulance. Review of the itemized billing will only be necessary for a small number of carve outs.

To arrive at the per diem reimbursement rates for the new ACIHFG, the per diem contract amounts for medical, surgical, and ICU/CCU services were averaged for each category on a state-wide basis. These averages revealed that the Commission's previous per diem reimbursement rate for acute care inpatient medical services is low ($600) when compared to the state-wide average per diem amount derived from the 1994-1995 hospital contracts and summaries ($870). The contract data also revealed that the Commission's previous per diem reimbursement rate for acute care inpatient surgical services ($1,100) is high when compared to the state-wide average per diem amount derived from the 1994-1995 hospital contracts and summaries ($1,045). Data analysis showed that the Commission's previous per diem reimbursement rate for intensive care unit services ($1,600) is high when compared to the state- wide average per diem derived from the 1994-1995 hospital contracts and summaries ($1,560). With the exception of the surgery rate, the rates in the new rule are the average per diem amounts by category derived from the 1994-1995 hospital contracts and summaries. Because hospitals have voluntarily contracted at these rates, these rates will provide fair and reasonable rates for workers' compensation, ensure access to quality care while achieving effective cost control and ensure workers' compensation fees are not in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living. Workers' compensation has significantly more acute care inpatient surgical cases as compared to medical or ICU cases. For the calendar year 1995, Commission data shows a total of 2,236 medical cases (representing reimbursements of $6,509,531) as compared to 5,632 surgical cases (representing reimbursements of $30,462,189) in the workers' compensation system. Total ICU cases could not be determined because this data is not segregated from the medical and surgical data. The Consumer Price Index (CPI) for the period from October 1, 1995 through December 31, 1996 and the estimated CPI for the year 1997 (the beginning of the time period covered by the hospital contracts requested by the Commission through the effective date of the new rule) increased approximately 7.0%.

Public comment received generally supported the proposed ACIHFG reimbursement rate of $870 for medical cases. Commenters did not express concern regarding the proposed ICU rate of $1,560 in the ACIHFG. However, these same commenters generally objected to the ACIHFG's proposed surgical rate of $1,045 as too low. Out of an abundance of caution to ensure access to quality surgical hospital care to injured workers and as an additional protection to ensure fair and reasonable rates for surgical cases, the Commissioners increased the surgical per diem reimbursement rate in the adopted ACIHFG from the per diem contract average surgical rate of $1,045 per day to $1,118 per day. This increase will provide additional reimbursement for those hospitals which experienced increases in payment from the rates contained in the 1994-1995 hospital contracts and summaries due to inflation. This increase is approximately 7.0% of the $1,045 rate and brings the surgical per diem rate to approximately 130% of the medical per diem rate of $870. This 130% difference between the surgical and medical per diem rates is equal to or greater than the corresponding differential in more than 80% of the managed care contracts obtained and considered by the Commission in setting the ACIHFG per diem rates. Just as the increases which result from the carve outs and the stop-loss provision, this increase in the surgical per diem rate will ensure injured workers' access to acute care inpatient services. In addition, this change to the surgical rate increases reimbursement for those cases which do not receive additional reimbursement provided by carve outs and the stop- loss provisions and serves as an additional protection to ensure fair and reasonable rates for surgical cases. The Commission utilized its expertise and experience to increase the surgical rate from the amount in the proposed rule to achieve a proper balance of the statutory standards, including effective cost control, discussed elsewhere in this preamble.

In recognition of the type of cases which may occur more frequently in workers' compensation than in other systems, the ACIHFG carves out the majority of the highest cost cases (eg. trauma and burns) from the reimbursement amount. This should compensate for any alleged reimbursement due for cases requiring a high level of services. The 1994-1995 hospital contracts and summaries were analyzed to determine what types of services and/or supplies were reimbursed outside or in addition to ("carved out of") the per diem rates in the contracts. A listing of the services and supplies carved out of the 1994-1995 hospital contracts was compiled and placed in order according to the frequency at which the carve out occurred in the contracts. All carved out items and services that are in any of the 1994-1995 hospital contracts (even those in less than 1.0%) and are applicable to typical workers'

compensation cases are included as carve outs in this rule and increase reimbursement. The ACIHFG Task Force gave input regarding applicability to workers' compensation cases. Carve outs are based on the 1994-1995 hospital contracts. The carved out services were identified by ICD-9 diagnostic codes and carved out supplies and equipment were identified by revenue codes. The following services and/or supplies are reimbursed in addition to the per diem rates in the new rule: MRI's (revenue codes 610 - 619) and CAT scans (revenue codes 350 - 352, 359); implantables (revenue codes 275, 276, and 278); hyperbaric oxygen (revenue code 413); blood (revenue codes 380 - 399); air ambulance (revenue code 545); and orthotics and prosthetics (revenue code 274). For the following ICD-9 codes, reimbursement for the entire admission shall be at a fair and reasonable rate: trauma (ICD-9 Codes 800.0 - 959.50); burns (ICD-9 Codes 940 - 949.9); and HIV (ICD-9 Codes 042 - 044.9). Pharmaceuticals greater than $250 charged per dose are reimbursed at cost plus 10% in addition to the per diem rate.

ICD-9 codes carved out of the ACIHFG are listed as a range of codes rather than by specific code because the number of codes which would need to be listed is so numerous it would create an undue administrative burden for all participants to list separately all codes which might be used as a primary diagnosis. Nearly all ICD-9 codes in the 800-900 series require fourth and fifth digit subclassification to fully identify the location and severity of trauma. This expands the actual number of codes in the series to more than a thousand, most of which clearly justify hospital admission. The listing of these carved out trauma and burn codes as a range rather than attempting to determine which codes should be included in a specific list is the most efficient method of identifying these carveouts for the Commission, hospitals, and insurance carriers and is also less administratively costly.

Implantables, orthotics, and prosthetics are to be reimbursed at cost to the hospital plus 10% of the cost to ensure that the cost of the item and related overhead costs are covered by the reimbursement. This method of reimbursement for revenue code carve outs is the predominant method used in the 1994-1995 hospital contracts. A ten percent addition was chosen because it was used in the previous ACIHFG, based on the recommendation of the Medical Advisory Committee that it would assure a reasonable return for the hospitals. In addition, commenters did not oppose the 10% add-on and the Commission has no data or information which would indicate that 10% is inadequate or excessive. Other carve outs are reimbursed at a fair and reasonable rate except pharmaceuticals with a charge greater than $250.

In addition to the ICD-9 codes and revenue codes carved out of the ACIHFG, pharmaceuticals with a charge greater than $250 per dose are also carved out of the per diem reimbursements. A dose is defined as the amount of a drug or other substance to be administered at one time. An analysis of the 1994-1995 per diem hospital contracts revealed that 119 (24%) of those contracts contained a carve out for pharmaceuticals. Fifty-three of those contracts used a monetary threshold per dose to determine the carved out pharmaceuticals. The majority of the 1994-1995 hospital contracts did not contain a dollar threshold, rather they listed specific drugs to be carved out of the contract rates. Because the Commission's intent was to exempt from the ACIHFG high cost drugs, a monetary threshold was the most efficient method of accomplishing that intent. Listing specific drugs as carve outs has the disadvantage of quickly becoming outdated as new drugs are introduced on the market. A monetary threshold avoids this problem. The threshold of $250 is chosen because it represents the 50th percentile of the array of monetary thresholds used in the 1994-1995 hospital contracts. In addition, $250 was the most commonly used threshold amount for pharmaceutical carve outs contained in the 1994-1995 hospital contracts. Carved out pharmaceuticals are reimbursed at cost to the hospital plus 10% of the cost to ensure that the cost of the drug and related overhead costs are covered by the reimbursement. The reasons for using a 10% add-on for pharmaceuticals are the same as explained previously for implantables, orthotics, and prosthetics. The carve outs increase hospital reimbursement and will ensure fair and reasonable rates for hospitals and ensure access to quality health care for injured workers by ensuring that hospitals will continue to treat workers' compensation patients. Auditing bills for pharmaceuticals greater than $250 per dose could increase administrative costs. However, cases where pharmaceuticals are greater than $250 per dose are anticipated to occur infrequently. Based on an analysis conducted by staff of the 1994-1995 hospital contracts, the pharmaceuticals carved out by name from those contracts are generally prescribed for cases of oncology, HIV, cardiac, neonatal, pregnancy, and infant care, which rarely occur in workersp compensation. Therefore, staff anticipates that since the occurrence of pharmaceuticals greater than $250 will be infrequent, any additional administrative costs will have little or no effect on the system

The new ACIHFG does not require that an invoice be submitted for reimbursement of implantables, orthotics, and prosthetics to avoid an unnecessary administrative burden for hospitals and carriers. In most situations, insurance carriers will know the usual cost of such items without examining the invoice for a particular item. Even though invoices are not required by this ACIHFG, the insurance carrier still has the option of auditing the bill from a hospital and requesting additional documentation, records, or information related to the treatments, services, or the charges billed. Attaching invoices to the bill for implantables, orthotics, and prosthetics requires additional time and expense for hospitals. TWCC believes there is a need for a determination of cost for implantables, orthotics, and prosthetics to a hospital. This need however, is outweighed by the significant burden to hospitals to continue this requirement. Therefore, this is no longer a requirement. Alternative ways for determining costs are available for insurance carriers. Hospitals and insurance carriers may develop a cooperative arrangement to obtain cost data when necessary for implantables, orthotics, and prosthetics. Insurance carriers are expected to not require these for all implantables, orthotics, and prosthetics and to confine it to those situations where the insurance carriers believe it is necessary to determine the cost from invoices.

The services and supplies chosen for carve out increase hospital reimbursement and will ensure fair and reasonable rates for hospitals and ensure access to quality health care for injured workers by ensuring that hospitals will continue to treat workers' compensation patients.

Review of the 1994-1995 hospital contracts and summaries received by the commission revealed that the average stop-loss threshold contained in those contracts is $39,524. Based on this average, the stop-loss threshold was set at $40,000. Because the basis of the per diem reimbursements were derived from the 1994-1995 hospital contracts, it is appropriate to use the average stop-loss threshold from the contracts. In addition, the analysis of the 1994-1995 hospital per diem contracts revealed that the average percentage reimbursement paid after the stop loss threshold is met is 72%. As a result, in the new rule, 75% is set as the percentage of total audited charges to be paid after the stop loss threshold of $40,000 is reached. The reduction of the stop-loss threshold to $40,000 is more of a reduction than it first appears, given the huge increase in hospital charges, such that a charge that was $50,000 in 1992, might be over $100,000 now. The reduction should therefore be viewed as a reduction from today's equivalent of a 1992 $50,000 charge, rather than a $10,000 reduction from $50,000 to $40,000. The stop loss threshold chosen increases hospital reimbursement and will ensure fair and reasonable rates for hospitals and ensure access to quality health care for injured workers by providing higher reimbursement for very high cost cases, ensuring that hospitals will continue to treat workers' compensation patients. Stop-loss applies only to those ICD-9 diagnosis cases that are not carved out. Therefore, this does not create an overlap and analysis will be possible for each factor. In the case of pharmaceuticals carve outs and carve outs identified by revenue codes, the whole bill is paid according to stop-loss provision if the stop-loss threshold is reached. Therefore there will be no overlap between carve outs identified by pharmaceuticals carve outs and carve outs identified by revenue codes and stop-loss, allowing analysis of each factor.

The new rule exempts from its provisions hospitals which have 100 or less licensed beds and which are located in a population center of less than 50,000 people. These hospitals are to be reimbursed at a fair and reasonable rate. Previous §134.400 of this title exempted "small/rural" hospitals from the reimbursement provisions of the guideline. A "small/rural hospital" was defined in previous rule §134.400 as an acute care hospital having fewer than 100 beds and less than $1,000,000 total annual revenue as determined by an audited financial statement from the prior fiscal year. Under this definition, so few hospitals qualified for the exemption that it was essentially meaningless. The exemption in new §134.401 is specific and definite and excludes from the per diem rates hospitals with 100 or fewer beds located in a population center of less than 50,000 people. With the exception of several small hospitals (each in population centers of 50,000 or more people) in the list of hospitals receiving the top 80% of workers' compensation reimbursement in 1994, contracts were not requested from hospitals which included the remaining 20% of workers' compensation reimbursement due to the small number of workers' compensation cases handled by such hospitals. The hospitals in the top 80% of workers' compensation reimbursement for 1994 did not include hospitals in population centers of less than 50,000 people. The Commission had insufficient data regarding the differing circumstances of hospitals in population centers of less than 50,000 people and the effect of these circumstances on the costs and payment rates of such hospitals. The Commissioners wished to protect and preserve the access to local hospitals for an injured worker who lives or works in a population center of less than 50,000 people. In addition, the Commissioners sought to avoid encouraging hospitals in population centers of 50,000 or more people to reorganize into smaller entities to seek exemption from the per diem reimbursements in the ACIHFG based upon the 100 or less licensed beds exemption. The list of hospitals which received approximately 80% of the total workers' compensation reimbursement paid to hospitals in 1994 included one hospital which had 100 or less licensed beds in a population center of 50,000 or more people. In 1995 the number of 100 or less bed hospitals in such population centers on this list increased to three. All of these hospitals on the list of top workers' compensation reimbursement recipients were located in population centers of greater than 50,000 people, and the average of their per diem contract rates was significantly less ($772 medical, $842 surgical in 1995; $822 medical, $908 surgical in 1996) than the rates contained in the adopted ACIHFG. Hospitals with 100 or less beds located in population centers of 50,000 or more persons operate in the same competitive environment as larger hospitals in the same or adjacent population centers of 50,000 or more persons and therefore, to meet such competition, must adjust what they are willing to accept as payment for similar services accordingly. Finally, while hospital payment data was utilized to determine average payments and to reflect competition in the hospital marketplace in population centers of 50,000 or more people, such data was not obtained for population centers of less than 50,000

The exemption of hospitals with less than 100 licensed beds located in a population center less than 50,000 people allows these hospitals to be reimbursed on a case by case basis ensuring access to care regardless of where an injured worker lives or works in Texas. Commenters who commented on the small hospital exemption suggested that hospitals with 100 or less licensed beds located outside Metropolitan Statistical Areas (MSA's) be exempted. Because there are sparely populated counties within MSA's, the Commission opted for the "located in a population center of less than 50,000 people" criteria as a more precise description of the local hospitals in small communities that were of concern regarding access to care and which it intended to exempt from the ACIHFG. The size of a population center is to be determined from the most recent Decennial Census of Population by the Bureau of the Census, U.S. Department of Commerce.

Reimbursement for these exempted hospitals is to be at a fair and reasonable rate. The exemption will ensure fair and reasonable rates for these hospitals and ensure access to quality health care for injured workers by ensuring that the exempted hospitals will continue to treat workers' compensation patients.

Outpatient services provided in a hospital setting are to be reimbursed at a fair and reasonable rate. Hospitals are required to maintain certain outpatient services on a 24-hour basis and may have different personnel costs than non-hospital sources of the same services. A Task Force member provided a list of charges from the member's hospital for typical outpatient services which suggested the costs of providing these services may be different

in a hospital setting than in non-hospital settings. The Commission does not have its own cost data regarding outpatient services provided in a hospital setting and as a result, cannot at this time confirm or dispute the contention that the costs of outpatient services are indeed different when provided in a hospital. Because reimbursement for typical outpatient services at the TWCC Medical Fee Guideline rates could affect access to services and quality of care for injured workers, those rates were not adopted for outpatient services performed in hospitals. Reimbursement for outpatient services is planned to be addressed in a future outpatient fee guideline after further study. For now, outpatient services will be reimbursed at fair and reasonable rates for hospitals. This will ensure access to quality health care for injured workers by ensuring that hospitals will continue to treat workers' compensation patients. Outpatient emergency services are not subject to this guideline. However, emergency room services associated with a hospital inpatient admission are subject to the guideline. Emergency professional services are not subject to this ACIHFG and are reimbursed in accordance with the Medical Fee Guideline in effect at the time the services are provided. Emergency transportation other than air ambulance will continue to be reimbursed in accordance with the Texas Workers' Compensation Commission Medical Fee Guideline in effect at the time the services are rendered.

During public comment, some commenters raised questions regarding the validity of using hospital managed care contracts as a basis for workers' compensation hospital reimbursements. The Texas Hospital Association (THA), among others, objected to the use of hospital contracts, alleging that workers' compensation cases were more complex and thus more costly than managed care cases. In an attempt to illustrate this alleged greater complexity, during the public comment on the previous proposal, THA submitted an analysis which compared the average Medicare relative weights for managed care cases to the average Medicare relative weights for Texas workers' compensation cases. Relative weights are assigned numerical indicators which reflect the relative resource consumption associated with each diagnostic related group. The Medicare relative weights are calculated by the Healthcare Financing Administration (HCFA) and published in the *Federal Register*. THA's analysis used an overall average of these relative weights to reach the conclusion that intensity of services for workers' compensation cases is 30% to 33% greater than managed care cases.

In its review of the THA complexity analysis, the Commission enlisted the expertise of Milliman and Robertson, Inc., one of the largest actuarial and management consulting firms in the United States, to compare complexity of workers' compensation cases to managed care cases. An actuarial study was performed by two actuaries from Milliman and Robertson: an actuarial specialist in health-related issues, including Medicare, Medicaid, and managed care who has worked with insurance companies, health maintenance organizations (HMOs), preferred provider organizations (PPOs), hospitals, employers, and government, and an actuarial specialist with particular expertise in workers' compensation and professional liability lines of insurance. A copy of this actuarial study is available at the Commission offices. The actuaries from Milliman and Robertson used two methods to analyze the complexity of workers' compensation as compared to managed care cases. The first method was essentially identical to that used by THA, except that THA used overall average Medicare weights and in the Milliman and Robertson study weights were compared separately by category of service. The Milliman and Robertson analysis concluded that the more appropriate ratios are the separate ratios for medical and surgical; i.e. medical is compared to medical, and surgical is compared to surgical. The Commission agrees with this approach; the Commission has always adopted separate medical and surgical rates.

Milliman and Robertson utilized categories of hospital services, and analyzed the number of workers' compensation cases for each category of service for January through June of 1995, and the Medicare relative weight assigned compared with a similar analysis of the number of cases for an HMO/PPO case mix provided by THA for the same period. When compared by category, none of the eleven categories are more complex for workers' compensation cases than for managed care cases as measured by Medicare weights. Milliman and Robertson concluded that the complexity of medical admissions for workers' compensation cases was just 79.9% of HMO/PPO cases unless rehabilitation cases were added to the medical cases in which case the workers' compensation cases would be 85.1.0% as complex as HMO/PPO cases. In addition, the analysis found that Texas workers' compensation surgical cases were 79% as complex as HMO/PPO surgical cases.

Milliman and Robertson also pointed out that Medicare weights represent not only the complexity of the particular DRG, but, in many cases, also the Medicare lengths of stay (LOS). For example, some DRGs have a higher relative weight, not because of complexity, but because the typical LOS is long. Thus, a higher weight does not necessarily mean the per day complexity would be at the same higher level. To correct for possible distortion because of Medicare length of stay (LOS), Milliman and Robertson used a second method to analyze the information. Medicare weights were divided by the average Medicare LOS. This calculation produces an average weight per day. For this analysis the LOSs for the managed care cases were estimated using Milliman and Robertson's hospital database for a managed care population in Texas. An overall LOS of 3.3 days was assumed with the average LOS of medical and surgical admissions at 3.9 days. The average LOS for workers' compensation cases was estimated using the overall LOS for 1995 based on the Commission's data (4.8 days for medical cases and 3.5 days for surgical cases). Milliman and Robertson adjusted their database to balance the average LOS to this experience. The results of the second analysis show that the complexity factor for medical admissions was .786 and the complexity factor for surgical admissions was .937. Both approaches clearly show, and Milliman and Robertson concluded that the complexity of workers' compensation cases for both medical and surgical stays is less than the complexity of typical managed care cases. In fact, the complexity factor of .786 was about identical to the .789 factor found in the study on categories of services described previously. Also, the complexity factor of .973 for surgical cases based upon the LOS analysis suggested to Milliman and Robertson that the low Medicare weights were partially due to lower length of stays for surgical admissions of workers' compensation claimants.

To determine whether the number of workers' compensation patients admitted to the hospital through the emergency room

affects the validity of using managed care contracts in determining workers' compensation reimbursements, the Commission analyzed its data for the year 1995 by comparing the date of admission to the date of injury from hospital bills received by the Commission. A hospital admission on the same day of injury would tend to indicate an emergency room case. Only approximately 18.5% of the cases were hospital admissions occurring the same day of injury. It is likely that some of these cases are not cases which entered through the hospital emergency room, because for instance, there are some circumstances in which a treating doctor may examine an injured worker and then immediately refer the patient for hospital admission. Of the 18.5% of cases which possibly enter the hospital through the emergency room, 78% were trauma cases and 5.0% were burn cases. Both of these ICD-9 codes (trauma and burns) have been carved out of the per diem reimbursements set in the ACIHFG and are reimbursed at a fair and reasonable rate. Therefore, over 80% of the workers' compensation emergency room entries will not be governed by the per diem rates, but will be reimbursed on an individual basis at a fair and reasonable rate, and the validity of using managed care contracts in determining workers' compensation reimbursements is not affected by emergency admissions in the workers' compensation system.

Another argument made by some commenters against the use of managed care contracts in determining workers compensation reimbursements was the inability of carriers to "steer" or require workers' compensation patients to obtain services at a particular hospital. The Workers' Compensation Act allows injured workers to choose their treating doctor, which necessarily leads to choice of hospital, because doctors are not automatically authorized to practice at every hospital. This means that carriers are unable to "steer' or require workers' compensation patients to obtain services at a particular hospital. Due to this aspect of the workers' compensation system, some commenters contend that workers' compensation is unlike managed care where hospitals allegedly negotiate contract rates in part based on the ability of carriers to assure certain numbers of patients, thus encouraging hospitals to lower rates in anticipation of increased patient volume. Commenters went on to contend that without this increased volume of patients (which workers' compensation could not guarantee) hospital contract rates were not applicable to workers' compensation and should not be used as a basis for workers' compensation reimbursement. However, in addition to these comments, other commenters pointed out that, in the current market hospitals are rarely given an exclusive contract because most hospitals cannot offer all the services necessary, most contracts do not guarantee a particular level of patient days or business, and contracting with a particular plan may be driven by the fact that the hospital does not want to be excluded as one of the provider hospitals in a plan. A review of the 1994-1995 hospital contracts received by the Commission supported these observations. Of the 1994-1995 hospital contracts for which full contract language (rather than a summary of contract terms) was provided to the Commission, only rarely was exclusivity included. Some of these contracts did provide incentives for staying within a particular healthcare network and some provided incentives for increased patient referrals. Although "steerage" of patients to a particular hospital for services may have been an important factor in negotiating hospital contracts in the early period of managed care contracting, the contract provisions indicate that it is less of a factor in the determination of hospital contract rates in the current market. During the meeting of the ACIHFG Task Force information was provided that indicated hospitals consider utilization when negotiating contract terms, as a result, utilization has already been accounted for in the contract rates.

Commenters opposed to the use of managed care contracts to determine workers' compensation reimbursement contend that managed care contracts were negotiated for a case mix different than workers' compensation and that workers' compensation reimbursement should therefore be greater than that in managed care contracts. The Legislature, in Texas Labor Code §413.011, provided that the Commission establish fees which do not provide for payment of a fee in excess of the fee charged and paid for similar treatment of an injured individual of an equivalent standard of living or by someone acting on that individual's behalf. This standard may not allow the Commission to consider whether the fee to be paid under the contract was established with reference to other fees set for the same payor. If the fee is paid for similar treatment for managed care patients, it may be argued that the fee paid for workers' compensation claimants should be no higher under this statutory standard. The Commission recognizes that absolute compliance with this statutory standard may not always be possible, but believes that the legislature intended it as a strong policy objective to which the Commission should apply its judgment and expertise when balancing all statutory standards and objectives. Strict adherence to this single provision could adversely affect access to quality health care and fair and reasonable fees which are also statutory standards and objectives.

In recognition of the type of cases which may occur more frequently in workers' compensation than in some other systems, the new rule sets per diem reimbursement for surgical services 7.0% above the average surgical per diem rate in the 1994-1995 hospital contracts and carves out some of the highest cost cases (eg. trauma and burns) from the per diem reimbursement amount. Workers' compensation has significantly more acute care inpatient surgical cases as compared to medical or ICU cases. For the calendar year 1995, Commission data shows a total of 2,236 medical cases (representing reimbursements of $6,509,531) as compared to 5,632 surgical cases (representing reimbursements of $30,462,189) in the workers' compensation system. Total ICU cases could not be determined because this data is not segregated from the medical and surgical data. The Consumer Price Index (CPI) for the period from October 1, 1995 through December 31, 1996, and the estimated CPI for the year 1997 (the beginning of the time period covered by the hospital contracts requested by the Commission through the effective date of the new rule) increased approximately 7.0%. The Commissioners increased the surgical per diem reimbursement rate in the adopted ACIHFG from the per diem contract average surgical rate of $1,045 per day to $1,118 per day. This increase will provide additional reimbursement for those hospitals which experienced increases in payment from the rates contained in the 1994-1995 hospital contracts and summaries due to inflation. This increase is approximately 7.0% of the $1,045 rate and brings the surgical per diem rate to approximately 130% of the medical per diem rate of $870. This 130% difference

between the surgical and medical per diem rates is equal to or greater than the corresponding differential in more than 80% of the managed care contracts obtained and considered by the Commission in setting the ACIHFG per diem rates. Just as the increases which result from the carve outs and the stop-loss provision, this increase in the surgical per diem rate will ensure injured workers' access to acute care inpatient services and serve as an additional protection to ensure fair and reasonable rates for surgical cases. This change to the surgical rate increases reimbursement for those cases which do not receive additional reimbursement provided by carve outs and the stop-loss provisions. The Commission utilized its expertise and experience to increase the surgical rate from the amount in the proposed rule to achieve a proper balance of the statutory standards, including effective cost control, discussed elsewhere in this preamble. In addition, the new rule carves out some of the highest cost cases (eg trauma and burns) from the per diem reimbursement amount. The additional surgical reimbursement, the carve outs, and the stop-loss provision should compensate for any alleged need for additional reimbursement based on case mix, case complexity, or length of stay.

Analysis of the 1994-1995 hospital contracts and summaries revealed that only 97 of the 1,321 per diem contracts contained some form of tiered per diem for surgical admissions. A per diem rate is said to be "tiered" when there is a difference in reimbursement based on which day of the hospital stay is being reimbursed. Supporters of tiering of surgical per diem rates base the need for tiering on the contention that more hospital resources are expended on the day of surgery than on the following days. The Commission chose not to use tiered per diems in this ACIHFG because, in the 1994-1995 hospital contracts and summaries received by the Commission, tiering was not the predominant method of utilizing per diem reimbursements. The Commission has no information to indicate that the per diem rates in the non-tiered managed care contracts do not represent services with various lengths of stay and various types and severity of injury/illness, and, in fact, believes that they do. As only 4.0% of the 1994-1995 hospital contracts carve out trauma, consideration of front loaded expense and severity must have been factors in negotiating the contract and thus in their negotiated per diem rates, and thus in the per diem rates adopted by the Commission. However, if there is front loaded expense and severity not accounted for in the hospital contracts, other provisions in the rule as adopted by the Commission will compensate for this, as they increase actual reimbursement. (See discussions elsewhere in this preamble regarding the exemption of certain small hospitals, stop-loss, carveouts, an addition of approximately 7.0% to the average surgical rate found in the 1994-1995 per diem contracts, and outpatient services.) The Commission concludes that tiered surgical rates are not necessary for a rate to be fair and reasonable, or to ensure access to quality health care. Because the average length of stay for surgical cases has declined on the average to be similar to surgical lengths of stay for managed care contracts, there is no need for a tiered per diem as a device to limit the lengths of stay.

The review of the information from the 1994-1995 hospital contracts and summaries received by the Commission revealed a variance in per diem reimbursements among hospitals. It has been suggested to the Commission that variations among contract rates is linked to hospital labor expenses, due to the fact that such expenses make up a major portion of total hospital expenses. Labor costs across regions as set out in the Bureau of Labor Statistics average hourly wage index for Texas metropolitan statistical areas (MSAs) were compared with the average hospital per diem rates contained in 1994-1995 hospital contracts for hospitals in the same region. No correlation between higher labor costs and higher per diem contract rates was observed; i.e. the higher per diem rates were not in the areas with higher labor costs. In fact, in some regions, there was a negative correlation-a region with a low wage index and very high managed care contract rates.

To further evaluate the variances in managed care contract rates, the Commission identified hospitals that are in the same chain, and looked at the contract rates for different hospitals contracting with the same company in the same MSA; for the same hospital contracting with the same company in different MSA's; and for the same hospital contracting with different companies in the same MSA. The analysis revealed that there is no consistency among hospitals in the same chain of hospitals which are contracting with the same company in the same MSA; there is no consistency among a specific hospital's contracts with the same company in different MSA's; and there is no consistency among a specific hospital's contracts with different companies in the same MSA. While there may be some basis or explanation for the variation in contract rates across the state, it is not differences in geographic location.

Hospital type and hospital bed size were also compared with the hospital per diem rates contained in the 1994-1995 hospital contracts. No factor was found which explained the reason for the differences in per diem contract rates. Differences which may be attributable to hospital and community size have been recognized and accounted for by the exemption for hospitals with 100 or less licensed beds located in a population center of less than 50,000 people from the per diem reimbursement rates in the new ACIHFG. (See discussion of exemption elsewhere in this preamble.) Differences in levels of care provided by some hospitals have been recognized and accounted for in the new ACIHFG by "carving out" or exempting from the per diem reimbursement rates, ICD-9 codes for trauma, burn and HIV cases. Other provisions in the new rule also serve to increase actual reimbursement. (See also, relevant discussion elsewhere in this preamble regarding increased reimbursement for surgical cases, stop-loss, carve outs, and outpatient services.) The Commission therefore concludes that regional rate variation is not necessary for the adopted rates to be fair and reasonable, or to ensure access to quality health care. Averaging minimizes the effect of outliers in the data because most rates were closer to the average than to either the higher or lower rates, because the lowest rates may not accurately reflect hospital economic factors for all the hospitals with greater rates and because a reimbursement based on an average rate will be a greater incentive for maintaining access to quality health care than use of the lowest rates.

Some commenters questioned how the new rule accounted for inflation in its reimbursement rates and advocated that an automatic adjustment be built into the ACIHFG. Inflation factors

are not the same each year, and in fact they can indicate decreases as well as increases in costs. Such factors cannot be accurately predicted into the future, and the Commission has not included an automatic predetermined future adjustment in the reimbursement rates provided in the ACIHFG

A number of commenters advocated use of the Bureau of Labor Statistics' (BLS) Consumer Price Index (CPI) for Medical Care Services as the basis for measuring appropriate changes in hospital reimbursement rates from year to year. THA used the CPI in its models to adjust what it contended are hospital charges and costs. According to the BLS the Medical Care Services CPI is a reflection of household expenditures for health insurance premiums as well as for out-of-pocket medical expenses. The Medical Care Services CPI does not include employer- paid health insurance premiums nor government-paid health care services such as Medicare. Whereas the Medical Care Services CPI may be a valid indicator of price change for some consumer expenditures, it is not necessarily indicative of hospital costs. As a result, the application of the Medical Care Services CPI as a measure of inflation in what it costs a hospital to provide services is suspect. A rise in consumers' out-of-pocket expenditures for health insurance premiums and medical expenses may be an indication of things such as a change in the way health care is paid for, a transfer of certain costs to the consumer, or the influence of managed care on the health care market. However, a rise in the Medical Care Services CPI does not necessarily indicate that hospitals should receive greater reimbursements. In view of this, the Commission did not directly use the Medical Care Services CPI to determine hospital reimbursement rates in the ACIHFG.

Nonetheless, the Medical Care Services CPI is commonly used as an indicator of inflation in costs to provide medical services and if applied, the hospital reimbursements in the new ACIHFG are sufficient to account for the inflation of 12% reflected in the CPI for the period from 1993 to 1996, and the new ACIHFG's estimated 17.4% increase over rates contained in the previous ACIHFG (which percentage does not account for any possible increased reimbursement due to the exemption of small hospitals located in a population center of less than 50,000 people) is just under the Medical Care Services CPI of 18% for the period 1993 to 1996

In addition, preliminary analysis of the approximately 300 per diem managed care contracts for the period October 1995 through October 1996, which have been received by the Commission indicates that with the exception of a few contracts, there was little or no change in the average per diem reimbursement rates ($863 medical per diem, $1,015 surgical per diem, and $1,537 ICU per diem) when compared to the average per diem rate of the contracts and summaries obtained earlier by the Commission. This preliminary analysis also indicates the total number of newer contracts that have per diem rates is increasing. In addition, a comparison of the averages of the newer contracts to the earlier contracts for the same hospital(s) indicates that 52.6% of these hospitals have more per diem contracts than before. A comparison of the newer contract rates to the earlier contract rates for the same hospital(s) shows that of the 692 per diem rates in the newer contracts 84.96% of the per diem rates were either reduced, stayed the same, or increased by less than 10%. Based on the comparison to inflation rates and the rates in the more recent contracts that have been analyzed, the Commission concluded that an overall future inflation adjustment is not necessary for the adopted rates to be fair and reasonable rates for these hospitals or to ensure access to quality health care for injured workers by ensuring that hospitals will continue to treat workers' compensation patients. However, out of an abundance of caution to ensure access to quality surgical hospital care to injured workers, and as an additional protection to ensure fair and reasonable rates for surgical cases, the Commission increased the surgical per diem reimbursement rate in the adopted ACIHFG from the per diem contract average surgical rate of $1,045 per day to $1,118 per day. The Commission utilized its expertise and experience to increase the surgical rate from the amount in the proposed rule to achieve a proper balance of the statutory standards, including effective cost control, discussed elsewhere in this preamble.

The Center for Health Care Industry Performance Studies' *1996-1997 Almanac of Hospital Financial and Operating Indicators* (as reported in *Medical Benefits*, October 30, 1996) reports that U. S. hospitals in high managed care markets realized significant improvements in profitability during 1995 and are more profitable than hospitals that operate in lower managed care markets. In addition, the *Almanac* reports that profitability in the hospital industry reached a five-year high in 1995. This publication presents information on hospital performance in 1995 and reviews performance measures for the past five-year period

The U.S. Prospective Payment Assessment Commission, a federal advisory panel, voted in January of 1997 to recommend no change in Medicare payment rates for hospitals (*Times, January 19, 1997)* The Commission concluded that hospitals had effectively controlled their costs, so that existing Medicare rates were generally adequate. Spokesmen for the advisory panel indicated that its recommendation would not harm the quality of health care or access to care for beneficiaries in the Medicare program. They indicated that Medicare hospital costs have been declining while Medicare payments have increased at a moderate rate, favorably affecting the profitability of the hospitals' Medicare business. In fact, the advisory panel's figures show that the operating expense for each Medicare patient has actually declined in the three year period of 1993 through 1995. The article states that the cost of medical care, as measured by the CPI, rose last year by just 3.0%, the smallest amount in three decades, and the first time since 1980 that medical prices rose less than the overall index. In addition, the article reports that economists told Congress last month that the CPI tends to overstate inflation. The advisory panel's recommendations and data and the statements regarding CPI inflation figures and medical care inflation provide additional indicators of why an overall future inflation factor is not justified for the adopted rates

After determining what the per diem rates would be, based on the 1994-1995 hospital contracts, the Commission wanted to compare those rates to Medicare rates. Because hospitals do a large volume of Medicare services and accept Medicare payment rates, the Commission believes that Medicare rates are fair and reasonable payment for Medicare patients, and ensure Medicare patients access to quality health care. The Medicare fee program is also designed to achieve effective cost control, another statutory objective the Commission must try to

meet in its own fee guidelines. Finally, the Commission believes that Medicare patients are persons of an equivalent standard of living to workers' compensation patients. Studies show that Medicare patients are of an equivalent standard of living to workers' compensation patients. The studies were performed by Research and Planning Consultants, Inc. and by Dr. Ronald T. Luke, Ph.D. J.D. who provide economic and public policy analyses to numerous public and private sector clients in health care matters including managed care organizations and who provide health cost management services with special attention to workersp compensation medical care cost. The most recent study noted that managed care has become the dominant form of health care coverage for U.S. workers. That study, also, noted that many low skilled and low paying jobs do not carry health insurance benefits and, therefore, workers covered by managed care plans have an equal or higher living standard than workers in general. The study utilized extensive health care literature and information. Therefore, the Medicare population is at least of an equivalent standard of living, and rates paid on their behalf for medical services are relevant to fair and reasonable rates for workers' compensation patients. For these reasons, it is relevant to consider estimated Medicare per diem rates. No hospital is required to participate in the Medicare program. The fact that hospitals accept Medicare rates (particularly for-profit hospitals), and the fact that Medicare reimbursements make up 40% of the gross patient revenue for Texas hospitals also indicates that Medicare rates are fair and reasonable.

To compare the ACIHFG rates proposed in the July 26, 1996 *Texas Register* with Medicare rates, the Commission again enlisted the expertise of Milliman and Robertson, Inc. A copy of this actuarial report is available for inspection at the Commission offices. Milliman and Robertson performed an actuarial study which calculated the estimated per diem rates at 1996 Medicare payment levels for five Medicare diagnostic related groups (DRGs 214 Back and Neck Procedures with complications, 215 Back and Neck Procedures without complications, 219 Lower Extremity and Humerus Procedure except Hip, Foot, Femur Age >17 without complications, 231 Local Excision and Removal of Internal Fixation Devices except Hip and Femur, and 243 Medical Back Problems). An analysis of TWCC's database shows that these five DRGs would have been the top five DRGs and would have accounted for approximately 60% of workers' compensation inpatient hospital payments in calendar year 1995 if a DRG descriptor were applied to Texas workers' compensation cases that year. The Milliman and Robertson study calculated Medicare per diem equivalent rates by starting with the 1996 Medicare base rate for each of 21 selected Texas cities representing the major metropolitan areas within the Texas Department of Health regions (Abilene, Amarillo, Austin, Beaumont, Brownsville, Corpus Christi, Dallas, El Paso, Fort Worth, Galveston, Houston, Longview, Lubbock, McAllen, Odessa/Midland, San Angelo, San Antonio, Tyler, Victoria, Waco, and Wichita Falls) and multiplying this base rate by the 1996 Medicare weight that is published in the *Federal Register* for each of the five chosen DRGs. The product of the Medicare weight and the base rate is the case rate. The case rate is divided by the Medicare average length of stay as published in the *Federal Register* to arrive at the estimated Medicare-based per diem amounts. This study concluded that the July 26, 1996 proposed ACIHFG per diem rates for surgical cases of $1,026 (with the carve out of implantables and a stop-loss threshold of $50,000) is similar to the Medicare reimbursement rates for DRGs 214 and 215 and consistently higher than Medicare reimbursement for DRGs 219 and 231. The medical per diem of $857 in the July 26, 1996 proposal of the ACIHFG averages about 80% higher than the calculated Medicare equivalent per diem for DRG 243.

For DRG 214, the estimated Medicare per diems ranged from $924 to $1,123, with the average being $1,014. Only two of the twenty-one estimated rates for DRG 214 were slightly higher than the $1,118 surgical rate adopted by this rule.

For DRG 215, the estimated Medicare rates ranged from $927 to $1,127, with the average being $1,017. Again, only two of the 21 estimated rates for DRG 215 were slightly higher than the $1,118 surgical rate adopted by this rule.

For DRG's 219 and 231, none of the estimated Medicare per diem rates was greater than $1,118. The average estimated rate for DRG 219 was $876, with the highest estimated rate being $148 less than $1,118. The average estimated rate for DRG 231 was $863, with the highest estimated rate being $162 less than the $1,118 rate adopted by this rule

For DRG 243, none of the estimated Medicare per diem rates was greater than $870. The average estimated rate was $465, with the highest estimated rate being $355 less than the $870 adopted by this rule for medical cases.

The rates adopted in this rule are greater than the rates contained in the July 26, 1996 proposal of the ACIHFG. The estimated Medicare per diem rates should not be compared with the reimbursement provided solely by the per diem rates in the adopted ACIHFG. The carve outs provided in the rule allow receipt of reimbursement additional to the per diem rate, and should serve to make hospital reimbursement for workers' compensation in all instances higher than the estimated Medicare per diem rates for the five DRG's

The Milliman and Robertson actuarial study concluded that the $50,000 stop loss threshold to a large extent offsets any possible additional Medicare reimbursement for outliers. The study also noted that in certain cases Medicare has additional payment rates for disproportionate share and indirect medical education. No adjustment to Milliman and Robertson's estimated Medicare equivalent per diem was made for these. The study concludes that the Medicare per diem amounts are probably overestimated because Medicare-age patients may have more complexity of care than similar cases The methodology did adjust for Medicare length of stay. The actuaries conclude that, if both LOS and the Medicare Index were adjusted to reflect Texas workers' compensation cases the per diems would be similar to those calculated. In addition, since the July 26, 1996 proposal, numerous "carve outs" or exemptions from the per diem rates have been added, the surgical per diem rate has been increased, and the stop-loss threshold has been lowered, which increases the ACIHFG reimbursements. This study shows that, for the five DRGs studied, under the per diem reimbursements contained in the July 26, 1996 proposed ACIHFG (and therefore in the adopted rule which increased the rates and decreased the stop loss threshold from the July 26, 1996 proposal), hospitals will receive

higher reimbursement for workers' compensation patients than they do for Medicare patients. This reinforces the Commission's conclusion that the per diem rates derived from the managed care contracts are fair and reasonable, will ensure access to quality medical care, will achieve effective cost control, and will not pay in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living. No additional adequate data was received from commenters or other sources to assess the propriety of utilizing a DRG- type methodology. The Commission has insufficient data at this time to determine whether use of DRG weights with a per diem system would be feasible or appropriate, especially given probable differences in complexity of case questions in the Medicare population where DRG reimbursement is used.

The public benefit expected as a result of adoption of the new rule is as follows. The Commission will comply with the statutory standards and objectives requiring the adoption of fair and reasonable rates.

Persons required to pay for inpatient hospital services, including employers, insurance carriers, the State of Texas and local governments, will pay fair and reasonable amounts for workers' compensation claimants which are similar to that paid for other patients and provide effective medical cost control.

Hospitals will receive a fair and reasonable amount in compliance with the statute for inpatient admissions.

Claimants will have access to quality health care services.

The guideline will be updated to provide for reimbursement amounts implementing medical cost containment measures designed to assure quality of medical care as required by the Texas Workers' Compensation Act.

It is anticipated that clear, fair guidelines will minimize disputes and encourage prompt payments to hospitals.

Concurrent with this adoption of §134.401, the Commission adopts the repeal of §134.400 of this title, the rule adopting the previous (1992) Acute Care Inpatient Hospital Fee Guideline (ACIHFG). Comments were received on the proposed new Acute Care Hospital Fee Guideline from: the Texas Hospital Association; Scott and White Hospital; Texas Association of Business & Chambers of Commerce; Patient Advocates of Texas; Business Insurance Consumers Association of Texas; Parkland Memorial Hospital; American Insurance Association; Resource Recovery Consultants; Alliance of American Insurers.

Comments expressing general support for the new rule were received from the following groups: Business Insurance Consumers Association of Texas; the American Insurance Association; and the Alliance of American Insurers.

Comments expressing general opposition to the new rule were received from the following groups: the Texas Hospital Association; Scott & White Hospital; Texas Association of Business & Chambers of Commerce; Parkland Memorial Hospital; and Resource Recovery Consultants.

Comments that did not specifically register a "for" or "against" position on the proposed rule were received from Patient Advocates of Texas.

Documents were also received in the form of questions. The Commission responded to the questions to the extent that the issues raised were clear, although the Commission was not obligated to do so, as the questions do not constitute comment.

Summaries of the comments and commission responses are as follows.

COMMENT: Several commenters addressed the exemption of hospitals with 100 or less licensed beds from the rule. Several commenters recommended exempting from the ACIHFG acute care hospitals with 100 or less licensed beds located outside a Metropolitan Statistical Area (MSA) or located in a rural area with reimbursement to be at a fair and reasonable rate, discouraging urban hospitals from reorganizing into smaller entities. A commenter suggested that the Commission create a code to be placed on the UB-92 and require that exempt hospitals stamp or electronically print this identifier on bills. A commenter suggested publishing a list of hospitals with 100 beds or less. A commenter questioned the justification for the changes, the reference in the preamble to the exemption as "essentially meaningless," and the implication that the exemption will be removed when the rule is adopted.

RESPONSE: The Commission agrees in part. The new rule exempts from its provisions hospitals which have 100 or less licensed beds and which are located in a population center of less than 50,000 people. These hospitals are to be reimbursed at a fair and reasonable rate. Previous §134.400 of this title exempted "small/rural" hospitals from the reimbursement provisions of the guideline. A "small/rural hospital" was defined in previous rule §134.400 as an acute care hospital having fewer than 100 beds and less than $1,000,000 total annual revenue as determined by an audited financial statement from the prior fiscal year. Under this definition, so few hospitals qualified for the exemption that it was essentially meaningless. The exemption in new §134.401 is specific and definite and excludes from the per diem rates hospitals with 100 or fewer beds located in a population center of less than 50,000 people. With the exception of several small hospitals (each in population centers of 50,000 or more people) in the list of hospitals receiving the top 80% of workers' compensation reimbursement in 1994, contracts were not requested from hospitals which included the remaining 20% of workers' compensation reimbursement due to the small number of workers' compensation cases handled by such hospitals. The hospitals in the top 80% of workers' compensation reimbursement for 1994 did not include hospitals in population centers of less than 50,000 people. The Commission had insufficient data regarding the differing circumstances of hospitals in population centers of less than 50,000 people and the effect of these circumstances on the costs and payment rates of such hospitals. The Commissioners wished to protect and preserve the access to local hospitals for an injured worker who lives or works in a population center of less than 50,000 people. In addition, the Commissioners sought to avoid encouraging hospitals in population centers of 50,000 or more people to reorganize into smaller entities to seek exemption from the per diem reimbursements in the ACIHFG based upon the 100 or less licensed beds exemption. Finally, while hospital payment data was utilized to determine average payment and to reflect competition in the hospital marketplace in population centers of 50,000 or more people, such data

was not obtained for population centers of less than 50,000 people. The list of hospitals which received approximately 80% of the total workers' compensation reimbursement paid to hospitals in 1994 included one hospital which had 100 or less licensed beds in a population center of 50,000 or more people. In 1995 the number of 100 or less bed hospitals in such population centers on this list increased to three. All of these hospitals on the list of top workers' compensation reimbursement recipients were located in population centers of greater than 50,000 people, and the average of their per diem contract rates was significantly less ($772 medical, $842 surgical in 1995; $822 medical, $908 surgical in 1996) than the rates contained in the adopted ACIHFG. Hospitals with 100 or less beds located in population centers of 50,000 or more persons operate in the same competitive environment as larger hospitals in the same or adjacent population centers of 50,000 or more persons and therefore, to meet such competition, must adjust what they are willing to accept as payment for similar services accordingly

The exemption of hospitals with less than 100 licensed beds located in a population center less than 50,000 people allows these hospitals to be reimbursed on a case by case basis ensuring access to care regardless of where an injured worker lives or works in Texas. Because there are sparely populated counties within MSA's, the Commission opted for the "located in a population center of less than 50,000 people" criteria rather than "outside a Metropolitan Statistical Area," as a more precise description of the local hospitals in small communities that were of concern regarding access to care and which it intended to exempt from the ACIHFG. The size of a population center is to be determined from the most recent Decennial Census of Population by the Bureau of the Census, U.S. Department of Commerce.

Reimbursement for these exempted hospitals is to be at a fair and reasonable rate. The exemption will ensure fair and reasonable rates for these hospitals and ensure access to quality health care for injured workers by ensuring that the exempted hospitals will continue to treat workers' compensation patients.

The Commission disagrees that it should require carriers to annotate billing forms to designate hospitals with less than 100 beds, because this information is already available. In addition, stamping or electronic imprinting would be a burdensome requirement for providers that deviates from standard billing practices. A list of hospitals with 100 beds or less can be obtained from the Texas Department of Health, Bureau of State Health Data and Policy Analysis, 1100 West 49th Street, Austin, Texas 78756-3199 (telephone number (512) 458-7347). This list can be used by insurance carriers to program their computers to flag small hospitals while they are programming other modifications as a result of the new ACIHFG. Since the Texas Department of Health already has this list available, additional lists by the Commission would duplicate services and be an inefficient use of state resources.

The Commission disagrees that there was an implication that the exemption would be removed, in fact it has been adopted with changes to the proposal.

COMMENT: A commenter felt that the statement in the guideline that services rendered prior to the effective date of the rule shall be subject to the ACIHFG in effect at the time services were performed, is contradictory to the Texas Supreme Court decision voiding the rule and voids the hospital s opportunity to appeal the determination of fair and reasonable reimbursement of claims processed under §134.400.

RESPONSE: The Commission agrees that the sentence "Medical and/or surgical inpatient services rendered prior to the effective date of this rule shall be subject to the ACIHFG in effect at the time the services were rendered should be deleted from subsection (a)(1)."

COMMENT: A commenter supported use of the Medical Fee Guideline (MFG) for reimbursement of outpatient services such as physical therapy, radiological studies and laboratory studies and suggested defining fair and reasonable to include the application of the MFG to outpatient services The commenter stated that application of the MFG to outpatient services would encourage hospitals to provide these services consistent with the statutory standards to ensure that the fee guidelines are fair and reasonable, and encourage effective and efficient medical cost control in order to ensure the injured workers receive quality health care. Another commenter supported hospital reimbursement for outpatient services outside the MFG at a fair and reasonable rate because hospitals encounter higher expense in providing these services (due partly to state and federal requirements, staff educational requirements, safety and fire requirements, hours of operation, on-call requirement and similar hospital unique needs that are required to meet national accreditation standards) than physicians' offices or outpatient clinics. A commenter suggested reimbursement for MRI/CAT scans to be in accordance with the Medical Fee Guideline except in cases of emergency services that do not result in an inpatient admission.

RESPONSE: The Commission disagrees that outpatient services should be included in this Acute Care Inpatient Hospital Fee Guideline. The Commission also disagrees that outpatient services and MRI/CAT scans should be reimbursed at Medical Fee Guideline rates. The Commission agrees that outpatient services and MRI/CAT scans should be reimbursed at fair and reasonable. The Commission does not at this time have sufficient data to set reimbursements regarding outpatient services provided in a hospital setting and as a result, cannot at this time confirm or dispute the contention that the costs of outpatient services are indeed different when provided in a hospital. Because reimbursement for typical outpatient services at the Medical Fee Guideline rates could affect access to services and quality of care for injured workers, the suggestion that such services be reimbursed at the Medical Fee Guideline rates has not been incorporated into the ACIHFG. These services are to be reimbursed at a fair and reasonable rate. This will ensure access to quality health care for injured workers by providing that hospitals receive fair and reasonable reimbursement for outpatient workers' compensation patients. Reimbursement for outpatient services is planned to be addressed in a future outpatient fee guideline after further study.

See also, relevant discussions elsewhere in this preamble, including discussion of outpatient services.

COMMENT: A commenter suggested the rule specifically define why other facilities are not subject to the rule and state that the guideline is not to be applied except where the rule intended.

RESPONSE: The Commission disagrees that further definition of the ACIHFG's application is necessary. The ACIHFG specifically states in subsection (a)(1) that it applies to acute care inpatient hospital stays. The Commission has other guidelines in development that will apply to other facilities. The rule is specific regarding the exemption of hospitals located in a population center of less than 50,000 persons and which have 100 beds or less and subsections (a)(2)-(5) specifically address reimbursement for other facilities/services until such time as specific guidelines are developed for those facilities/services which provide for fair and reasonable reimbursement according to the statutory standard set out in the Texas Labor Code. Insurance carriers are to provide reimbursement for those other facilities/services in accordance with those standards. Providers who disagree with the amount they are reimbursed may seek dispute resolution through the Medical Review Division of the Commission. Only acute care inpatient hospital services will be reimbursed within the per diem rate structure in the ACIHFG because this guideline was developed to regulate only acute care inpatient stays and the research performed only pertained to acute care inpatient hospital stays. Therefore, this guideline does not apply to other types of facility services. The rule itself does not need to explain why certain facilities are not subject to the rule.

COMMENT: A commenter supported the requirement that payment be the lesser of the per diem, the amount billed, or the contracted amount.

RESPONSE: The Commission agrees.

COMMENT: Commenter disagrees with the elimination of the requirement for hospitals to attach a copy of the invoice for durable medical equipment and implantables. The commenter states it is difficult for carriers to determine the cost to the facility without the invoice.

RESPONSE: The Commission disagrees. Attaching invoices to the bill for implantables, orthotics, and prosthetics requires additional time and expense for hospitals. TWCC believes there is a need for a determination of cost for implantables, orthotics, and prosthetics to a hospital. This need however, is outweighed by the significant burden to hospitals to continue this requirement. Therefore, this is no longer a requirement. Alternative ways for determining costs are available for insurance carriers. Hospitals and insurance carriers may develop a cooperative arrangement to obtain cost data when necessary for implantables, orthotics, and prosthetics. Even though invoices are not required by this guideline, the insurance carrier still has the option of auditing the bill from a health care provider and requesting additional documentation, records or information related to the treatments, services, or the charges billed. Insurance carriers are expected to not require these for all implantables, orthotics, and prosthetics and to confine it to those situations where the insurance carriers believe it is necessary to determine the cost from invoices.

COMMENT: Commenter questioned the definition of "per dose" as used in subsection (c)(4)(C). Commenter stated that a detailed audit of the sometimes lengthy bill would be required to identify a drug billed at greater than $250, as lengthy, itemized hospital bills are generally sorted by date of service rather than by type of service and frequently includes a charge for a drug on one day and a credit for the drug of a subsequent day. A detailed audit may increase administrative costs and in turn increase the overall cost impact of these carve outs.

RESPONSE: The Commission agrees that subsection (c)(4)(C) should be clarified. The subsection has been revised to read "$250 charged per dose". This change clarifies that it is the charged amount that determines the carved out applicability. The following sentence will also be added to further clarify the subsection. "Dose is the amount of a drug or other substance to be administered at one time." The $250 charged per dose would be reflected as a line item charge on the detailed bill by the hospital. The Commission agrees that auditing bills for pharmaceuticals greater than $250 per dose could increase administrative costs. However, cases where pharmaceuticals are greater than $250 per dose are anticipated to occur infrequently. Based on an analysis conducted by staff of 1994-1995 hospital contracts and summaries received by the Commission, the pharmaceuticals carved out by name from those contracts are generally prescribed for cases of oncology, HIV, cardiac, neonatal, pregnancy, and infant care, which rarely occur in workers' compensation. Therefore, staff anticipates that since the occurrence of pharmaceuticals greater than $250 will be infrequent, any additional administrative costs will have little or no effect on the system.

COMMENT: Commenter expressed concern that the ICD-9 diagnosis codes listed in subsection (c)(5)(A) and (B) include diagnosis codes that do not require specialized care or services of increased intensity. The identified trauma codes include diagnoses such as finger or toe fractures, dislocations, sprain/strains, simple contusions, and superficial injuries. The burn codes include all severities of burns, including those involving limited body surface areas or those of little more severity than to cause erythema. The commenter suggested that a clear definition be provided and that the list contain only ICD-9 codes that require specialized care or services of increased intensity.

RESPONSE: The Commission agrees that the span of ICD-9 diagnosis codes indicated in subsection (c)(5)(A) and (B) includes codes for relatively minor injuries, but disagrees that carved out ICD-9 codes should be specifically listed. It would create an undue administrative burden to list separately all codes which might be used as a primary diagnosis. Nearly all ICD-9 codes in the 800-19959 series require fourth or fifth digit subclassification to fully identify the location and severity of trauma. This expands the actual number of codes in the series to more than a thousand, most of which clearly justify hospital admission. The listing of these carved out trauma and burn codes as a range rather than attempting to determine which codes should be included in a specific list is the most efficient method of identifying these carve outs for the Commission, hospitals, and carriers and is also less administratively costly.

The inclusion of codes for less severe injuries in this range of codes identifying carve outs will not present a problem because these codes represent conditions which, by themselves, probably would not require admission for inpatient hospital treatment. While these codes could be used appropriately to classify adjunct or secondary diagnoses, they would be inappropriate to

use for coding a primary diagnosis, that is, the condition responsible for the greatest portion of the overall length of stay. Consequently, codes for less severe injuries should not appear as the primary diagnosis on a properly prepared UB-92 submitted for payment of inpatient expenses and therefore, would not be confused as a case which is carved out of the ACIHFG.

In addition, the incidence of miscoding a less severe injury as the primary diagnosis occurs infrequently. A review of calendar year 1995 payment data showed that UB-92s with a minor injury code in first position comprised only 2.4% of trauma- related (ICD-9 codes 800-19959) cases. These cases accounted for only 1.05% of reimbursements for trauma-related hospitalizations and for only 0.09% of payments for all inpatient reimbursements during the year. After further review of selected bills with minor injury codes listed as the primary ICD-9 diagnosis code, additional ICD-9 codes for more severe conditions (*e.g.*, first position: 942.14, first degree burn of trunk; second position: 945.24, second degree burn of lower leg; third position: 948.00, third degree burn covering less than 10% of the body surface) were specified on those same bills.

COMMENT: Commenters disagreed with the lowering of the stop-loss threshold at this time and suggested that it be set at $50,000 and be reassessed when the impact of carve outs is determined. Both the stop-loss and the carve outs are designed to identify unusually expensive treatments and services and the two will overlap to some degree. If both are changed at one time, it will be difficult to know the impact of either change on its own.

RESPONSE: The Commission disagrees that the stop-loss threshold should be raised to $50,000. Review of the 1994-1995 hospital contracts and summaries received and analyzed by the Commission revealed that the average stop-loss threshold contained in those contracts was $39,524. Based on this average, the stop-loss threshold amount in subsection (c)(6)(A)(i) has been set at $40,000. Insufficient data exists to determine what changes, if any, would need to be made to the per diem rates if the stop-loss was set based on something other than the average market based amount in the managed care contracts. The Commission disagrees that the effects of stop-loss and carve outs in the ACIHFG will overlap. Stop-loss applies only to those ICD-9 diagnosis cases that are not carved out. Therefore, this does not create an overlap and analysis will be possible for each factor. In the case of pharmaceuticals carve outs and carve outs identified by revenue codes, the whole bill is paid according to stop-loss provision if the stop-loss threshold is reached. Therefore there will be no overlap between carve outs identified by pharmaceuticals carve outs and carve outs identified by revenue codes and stop-loss, allowing analysis of each factor.

See also, relevant discussions elsewhere in this preamble, including discussion of stop-loss provision.

COMMENT: A commenter supported the carve outs included in the ACIHFG. Another commenter agreed with the carve out reimbursement as long as administrative costs do not significantly increase when determining when the threshold is met. In addition, this commenter suggested if a tiered per diem rate for surgery was included in the guideline then carve outs should be limited to the most difficult problems such as burn and trauma. There may be some simple changes in the way hospitals bill for these codes that the TWCC could require to facilitate the administration of this carve out.

RESPONSE: The Commission agrees that carve outs should be included in ACIHFG. Although initial administrative set up costs for this guideline will be necessary for both insurance carriers and hospitals, carve outs should not significantly impact the administrative costs to the system. The Commission expects that most of the information necessary to determine reimbursement for carve outs will come directly from the UB-92 form because ICD-9 codes which cover the trauma, burn, and HIV carve outs, are listed directly on the UB-92. Revenue codes are also directly listed on the UB-92 for MRI, CAT scans, hyperbaric oxygen, blood and air ambulance. Review of the itemized billing will only be necessary for a small number of carve outs. A tiered reimbursement for surgery was not adopted so review of carve outs in that context was not an issue.

COMMENT: Commenter stated that managed care contracts are appropriate for determining workers' compensation reimbursement and arguably required by the statute. Commenter supported the use of managed care contracts as a measure of acceptable reimbursement to ensure both quality of care and to ensure that workers' compensation does not pay more than other payors. Another commenter expressed the opinion that the justification set out in the preamble to the rule for using the managed care contracts in setting rates is inadequate and inconsistent with the reasoning stated in the Medical Fee Guideline preamble (21 TexReg 2388), representing a conflict in policy and questioned the Commission's motive to use a basis which resulted in the lowest reimbursement to different segments of health care providers. The commenter questioned why utilization data was excluded from managed care contracts.

RESPONSE: The Commission agrees that managed care contracts are appropriate for determining workers' compensation reimbursement for acute care inpatient hospital services. Discussion of use of managed care contracts and the addition of approximately 7.0% to the average surgical per diem rate in the 1994-1995 per diem contracts is presented in this preamble. The Commission disagrees that using the managed care contracts for setting per diem rates is inconsistent with the reasoning used in the development of the Medical Fee Guideline (MFG). The MFG establishes maximum allowable reimbursements for services provided by health care practitioners. Managed care contract reimbursement rates for primary care health care practitioners often are based on a capitation type reimbursement method which usually does not provide specific amounts for specific services. In addition, unlike acute care inpatient hospital reimbursement data, the data utilized for the MFG (§134.201) for the early 1990's did not reveal that Medicare plus managed care reimbursements constituted a majority of total reimbursements for non-workers' compensation cases. Because of this, data from managed care contracts with health care practitioners was not utilized for development of §134.201 (MFG). Instead, fee for service data was utilized as the basis for deriving the maximum allowable reimbursement amounts for the MFG (§134.201). On the other hand, as described in detail previously in this preamble, managed care contracts with hospitals were determined to be the best indication of a market price voluntarily negotiated for hospital services. The development of

fee guidelines which comply with statutory standards requires the careful analysis of available data and reimbursement options for the services to be covered by the guideline. The same methodology may not be appropriate for every guideline. In analyzing the managed care contract data it was observed that managed care contracts included contracts for workers' compensation acute care, inpatient hospital stays where rates were set at or below the lower per diem rates in the Commission s previous ACIHFG. Utilization data was not specified on any consistent basis in the 1994-1995 hospital contracts and was not included at all in some of those contracts. In addition, the across-the-board inclusion of fair and reasonable reimbursement rates for carved out services in the guideline plus the stop-loss provision provides substantial protection for a hospital with lesser numbers of workers' compensation patients.

COMMENT: Commenters contend that because by statute workers' compensation carriers cannot direct injured workers to a particular hospital, the managed care contract rates are not applicable to workers' compensation. Commenters objected to the use of managed care contract rates to set rates for the ACIHFG because they contend that hospitals enter into contract agreements with the expectation that payors will generate additional admissions for the hospitals. Commenters stated that these additional admissions would come as a result of financial incentives or penalties encouraging selection of providers inside the network and not through specific managed care contract clauses. In addition, a commenter contends that hospitals evaluate their HMO/PPO contracts on a regular basis and will either modify or terminate those contracts that have not brought a sufficient volume of business to the hospital to justify the price discount in the contract.

RESPONSE: The Commission disagrees that the managed care contracts are not applicable for determining Workers' Compensation reimbursement. Managed care contracts constitute a valid base rate that reflects the marketplace for inpatient hospital services as described in detail elsewhere in this preamble.

For those 1994-1995 hospital contracts for which full contract language (rather than a summary of contract terms) was provided to the Commission (1,320 actual contracts), only rarely was any type of exclusivity language included which would have required a patient to use the hospital(s) specified in a contract. In addition, "steerage" of patients to a particular hospital has markedly decreased as an important factor in the determination of hospital contract rates as managed care contracts are updated. Typically managed care organizations contract with every hospital in an area. In response to a previous proposal of this guideline, commenters pointed out that, in the current market hospitals are rarely given an exclusive contract because most hospitals cannot offer all the services necessary, most contracts do not guarantee a particular level of patient days or business, and contracting with a particular plan is increasingly driven by the fact that a hospital does not want to be excluded as one of the provider hospitals in a plan rather than any probable increase in the number of patients. The Commission's experience and review of 1994-1995 hospital contracts supports this. As the Commission periodically reviews its guidelines, in the future, trends in hospital reimbursement including changes in provisions in more recent hospital contracts will be evaluated. If changes are observed which reflect any reversal of the lessening importance of "steerage" of patients to particular hospitals, that factor will be evaluated and taken into consideration in revising the ACIHFG.

In addition, the fair and reasonable reimbursement provisions for the "carve out" services and stop-loss provisions both provide substantial protection to hospitals which need to provide substantially greater than normal services to a smaller number of patients.

COMMENT: Commenters objected to the Commission's use of managed care contract rates to set rates for the ACIHFG because they contend that workers' compensation patients do not receive similar treatment to patients enrolled in an HMO/PPO plan. The commenters state that approximately 73% of workers' compensation patient admissions are surgical as opposed to 28% of HMO/PPO admissions and therefore contend that workers' compensation patients receive, on average, more intensive and more costly hospital services. Commenter stated that the surgical per diem rates in many managed care contracts are below the hospitals' usual price for surgical services because it is anticipated that any losses on the surgical admissions will be more than offset by the payments received on medical admissions. Commenter stated that hospitals consider their aggregate costs and payments for services provided to enrollees of the plan. Commenter believed that when the hospitals treat HMO/PPO patients the hospitals probably will cover their cost and make a small profit because of the money made on the medical cases offsets the losses on the surgical side, and this is not possible with workers' compensation patients because the majority of the admissions are surgical. The commenters recommend that the Commission establish rates that reflect the type and complexity of services provided to workers' compensation patients. Commenter stated that because many managed care contracts may be for large groups or employees, hospitals may accept certain contracts based upon member utilization of lower cost surgeries, medical admissions and intensive care or cardiac care services. Commenter felt that the managed care data complicates the issue because most managed care admissions are medical, pediatric, and obstetrical. Another commenter stated that managed care contracts are negotiated on a basis of a totally different population of patients. Commenter asked if hospitals were questioned about this or if any data was reviewed, requested or analyzed relative to this possibility and to determine utilization patterns, although commenter did not state whether this should have been done and if so why he believes that.

RESPONSE: The Commission disagrees that workers' compensation patients receive more intensive and more costly hospital services than HMO/PPO patients. An actuarial study was performed by the nationally recognized firm of Milliman and Robertson, Inc. and by actuaries with extensive experience in the typical case mix for workers' compensation claimants and for managed care payors. The study utilized case mix comparisons provided by the Texas Hospital Association (THA) to the Commission in support of the commenters' position. However, Milliman and Robertson found that the commenter's position was not only insupportable but that workers' compensation patients received, on the average, substantially less intensive and costly service than the average managed care patient. Therefore the rates in the new ACIHFG do reflect the type and complexity

of services provided to workers' compensation patients. See the description of this study elsewhere in this preamble. Milliman and Robertson utilized categories of hospital services, including four maternity categories, three mental health and psychoactive substance abuse categories, and four other hospital admission categories which were subdivided into medical, surgical, rehabilitation and unclassified admissions. The Milliman and Robertson analysis utilized the number of workers compensation cases for each category of service for January through June of 1995 and the Medicare relative weight assigned compared with a similar analysis of the number of cases for a THA-supplied HMO/PPO case mix for the same period. When compared by category, all eleven categories were less complex for workers' compensation cases than for managed care cases as measured by Medicare weights. Milliman and Robertson noted that there were very few workers' compensation cases in categories other than medical and surgical and concluded that the complexity of medical admissions for workers' compensation cases was just 79.9% of HMO/PPO cases unless rehabilitation cases were added to the medical cases in which case the workers' compensation cases would be 85.1.0% as complex as HMO/PPO cases. In addition, the analysis found that Texas workers compensation surgical cases were 79% as complex as HMO/PPO surgical cases.

Testimony by hospital representatives at the public hearing on the previous proposal of this rule revealed that generally hospitals do not knowingly negotiate contract rates for any type of service where the hospitals lose money in providing that service.

The Legislature in Texas Labor Code §413.011 mandated that the Commission establish fees which do not provide for payment of a fee in excess of the fee charged and paid for similar treatment of an injured individual of an equivalent standard of living or by someone acting on that individual's behalf. This standard may not allow the Commission to consider whether a fee to be paid under a contract was established with reference to other fees set for the same payor. If the fee is paid for similar treatment for managed care patients, arguably the fee paid for workers' compensation claimants should be no higher under this statutory standard. The Commission recognizes that absolute compliance with this statutory standard may not always be possible, but believes that the legislature intended it as a strong policy objective to which the Commission should apply its judgement and expertise when balancing all statutory standards and objectives. The Commission has used its judgment and expertise in making its decision to use averages of the per diem hospital rates in the 1994-1995 hospital contracts (with the addition of approximately 7.0% to the surgical per diem average) as a basis of the rates in this ACIHFG.

In recognition of the types of cases which may occur more frequently at one hospital than at another, the ACIHFG carves out the majority of the highest cost cases (e.g. trauma and burns) from the per diem reimbursement amount. These carved out cases, the increased surgical per diem rate, and the stop-loss provisions provide adequate compensation for any additional reimbursement due for workers' compensation patients based upon a particular hospital's possibility of a disproportionate case mix, case complexity, or length of stay.

Hospitals were not questioned or surveyed regarding their acceptance of contracts due to member utilization of low cost surgeries, medical admissions and intensive care or cardiac care services, because these factors are part of the private negotiation process and would not normally be documented. During the meeting of the ACIHFG Task Force information was provided that indicated hospitals consider utilization when negotiating contract terms, as a result, utilization has already been accounted for in the contract rates.

COMMENT: Commenter questioned whether the Commission made adjustments to managed care contracts rates for those hospitals that provide a high level of services to injured workers. The commenter also questioned the relevance of managed care contracts to workers' compensation if these contracts do not provide for services to injured workers.

RESPONSE: The Commission agrees that cases which require a high level of services should be taken into consideration in setting rates and the adopted rule does so. In recognition of the type of cases which may occur more frequently in workers' compensation than in the other systems, the ACIHFG carves out the majority of the highest cost cases (e.g. trauma and burns) from the per diem reimbursement amount and provides stop-loss reimbursement for cases with total audited charges of which exceed $40,000. This, plus the addition to the surgical per diem rate, should compensate for any alleged additional reimbursement due for cases requiring a high level of services.

Some of the 1994-1995 hospital contracts included worker's compensation cases and approximately 1.3% of the contracts were for workers' compensation cases only. The reimbursement rates specified for workers' compensation cases in the managed care contracts were at rates either at or below the previous ACIHFG (i.e., at rates significantly less than the adopted new ACIHFG rates). The relevance of the managed care contracts to the ACIHFG, whether the contracts included workers' compensation cases or not, is demonstrated by the Texas Department of Health's 1995 report. The report shows that 40% of gross patient revenue for Texas hospitals came from Medicare and 33.3% came from third party payors, including payments made pursuant to managed care contracts. Because third party payors are the second largest payor group in terms of gross patient revenue, the amounts paid to hospitals by third party payors are relevant to determining fair and reasonable workers' compensation reimbursements to hospitals.

Texas Labor Code §413.011, which provides that the Commission establish fee guidelines, specifies that those guidelines may not provide for payment of a fee in excess of the fee charged and paid for similar treatment of an injured individual of an equivalent standard of living or by someone acting on that individual's behalf. To comply with this legislative standard, the Commission reviewed the payments made for health care services outside the workers' compensation system. The managed care contracts are directly relevant to the hospital fee guideline rule-making proceeding.

Managed care contracts, which reflect voluntarily negotiated market prices, are relevant to ensuring fair and reasonable reimbursement [§413.011(b)]. They show rates a business (a hospital) which voluntarily accepts patients is willing to accept for provision of services.

Managed care contracts are relevant to achieving cost control [§413.011(b)] because they offer negotiated services at lower rates for the working age population, which is also the population of workers' compensation injured workers as described elsewhere in this preamble.

Managed care contracts are relevant to ensuring access to quality care [§413.011(b)], because as voluntarily negotiated rates, they reflect rates at which a hospital will continue to take patients.

Managed care contracts are relevant to the statewide database [§413.007] the Commission is required to maintain: a database of charges, actual payments, and treatment protocols that is sufficient to detect practices and patterns in charges and payments and can be used in a meaningful way to control costs.

The managed care contract information is highly reliable; it was obtained directly from the hospitals. Either copies of the actual contracts were provided or certified summaries of information from the contracts were provided by the hospitals.

COMMENT: Commenter questioned why the Commission did not use diagnostically related groups (DRGs) as the basis for reimbursement in the proposed ACIHFG and questioned if there is an inherent flaw in using only broad categories of services for per diem rates.

RESPONSE: Prospective payment methods, in addition to the per diem method ultimately chosen, were among the alternative reimbursement methods considered. Prospective payment amounts can be determined by using diagnostic-related groups (DRGs). The DRG method of reimbursement involves paying the hospital a predetermined fee based upon the patient's diagnosis rather than for example the length of stay or specific services provided. DRGs were not used as the methodology for this ACIHFG for several reasons. First, while Medicare utilizes DRGs, Medicare reimbursement rates for those DRGs are not based upon market-driven forces and largely involve non-working elderly patients who may require longer lengths of stay and a higher percentage of co-morbidity. Second, the percentage of the 1994-1995 hospital contracts utilizing DRG methodologies was 10.8% and, therefore, would not be as representative of the reimbursements as per diem contracts which comprised 51.5% of the 1994-1995 hospital contracts. Third, only about five out of the approximately 494 DRGs used by other payors make up an estimated 60% of inpatient hospital workers compensation cases. No data was received or could be located which would indicate how the workers' compensation cases within these five DRG'S would be comparable to the typical Medicare cases in terms of complexity and intensity of care. Without such data, setting reimbursement rates within the statutory standard would be extremely difficult, if not impossible. The per diem rate methodology plus the carve out services results in a more careful consideration of factors. In addition, the Commission has not received data from hospitals based upon DRGs because DRG designations are not reported on bills received by the Commission and no additional adequate data was received from commenters or other sources to further assess the propriety of utilizing a DRG-type methodology. The Commission has insufficient data at this time to determine whether use of DRG weights with a per diem system would be feasible or appropriate, especially given probable differences in complexity of case questions in the Medicare population where DRG reimbursement is used.

COMMENT: Commenter challenged the method used in the actuarial study to compare Medicare reimbursement to workers' compensation reimbursements. The commenter thought that Medicare patients within the five DRGs mentioned in the study would probably have an average length of stay in excess of that for an injured worker. The commenter thought that any conclusion in the study derived from a comparison of DRG payments made by lump sum with the proposed per diem amounts for the ACIHFG would have little meaning. The commenter concluded that dividing a DRG payment by the average length of stay for a Medicare patient, which is higher, and then multiplying the result by the average length of stay for an injured worker, which is lower, would seem to be inappropriate. The commenter questioned the relevancy of the study. The commenter also questioned how Medicare payments can be compared only by considering the average per diem and why the DRG data was not adjusted for diagnosis and procedure codes and why Medicare grouper and pricer models were excluded from those comparisons.

RESPONSE: The Commission disagrees that the methodologies used and the conclusions reached in the actuarial study are faulty. The actuarial study was performed by the nationally recognized actuarial firm of Milliman & Robertson, Inc. and by actuaries with extensive experience in hospital reimbursements for both workers' compensation claimants as well as many other purchasers of health care; in the typical case mix for workers' compensation claimants and for patients of other payors; and in hospital stays by DRG mix. The study compared Medicare payment rates for 21 Texas cities with the previous proposed ACIHFG per diem rates utilizing the 1996 Medicare base rate for each of those cities which was multiplied by the 1996 Medicare weight published for each of the five DRGs. The product of the Medicare weight and the base rate was the case rate. The case rate was divided by the Medicare average length of stay published in the Federal Register to determine the implied Medicare per diem rate. No adjustment was made for the fact that Medicare- age patients may have more complexity for back and neck problems than the typical workers' compensation cases. Any such adjustment would have decreased the amount of the implied Medicare per diem rates and therefore demonstrated that the previous proposed ACIHFG rates were at an even higher percentage of comparable Medicare rates. The study concluded that, for the five DRGs, hospitals will receive higher reimbursement for workers' compensation patients in Texas than they do from Medicare patients in the same DRGs. The studies utilized data showing that the Medicare average length of stay was greater than for injured workers. Therefore, the payments made by Medicare and the payments previously proposed for the ACIHFG were compared only after being divided by the corresponding average length of stay for Medicare patients and for injured workers hospitalized in Texas. The study, therefore, was able to convert two different payment systems to provide an equivalent per diem rate comparison of payment amounts between the two systems for the most common inpatient, acute care hospital services rendered to Texas injured workers

The study is particularly relevant because Medicare is the largest payor for Texas hospitals (e.g., approximately 40% for 1995 year) and because of the statutory requirement that the Commission's fee guideline not pay more than what is paid for similar services for persons with an equivalent standard of living. While the commenter is generally correct in assuming that the methodology of the study included dividing a DRG payment by the average length of stay, the commenter incorrectly assumed that the study multiplied the result by the average length of stay for an injured worker because such multiplication was not done. The methodology of each study was clearly indicated in each report and those reports were and are available to the public.

Because the Medicare price comparison study utilized Medicare DRG payment amounts when comparing with the previously proposed ACIHFG per diem amounts to be paid in the medical, surgical, and ICU categories for all procedures and diagnoses in those categories, no further adjustments for individual codes or procedures were necessary and, therefore, consideration of Medicare grouper models was not appropriate.

In addition, the study did consider other possible adjustments to the Medicare reimbursement rate. No adjustments for outlier rates for the 5 DRGs in the comparison were made because the incidence of outlier claims for these DRGs would be relatively infrequent and would have a minor impact and because the previous proposed ACIHFG s stop-loss provisions would largely offset the additional Medicare reimbursement. No adjustment was made for Medicare disproportionate share and for indirect medical education because not all hospitals receive payments for these amounts and such payments are usually relatively minor. No adjustment was made for hospitals paid on a cost basis because this basis for payment is being phased out in favor of the Medicare conventional payment basis. Another reason for the decision on these possible adjustments was the countervailing lack of adjustment for the fact that the Medicare population may have more complexity for back and neck problems than the typical workers' compensation cases.

Finally, after the study was completed based on the previously proposed ACIHFG, the Commission issued its revised proposed ACIHFG which contained increased per-diem rates, carve outs which increases reimbursement, and lowered stop-loss thresholds which increases reimbursement. Therefore, inclusion of these additional reimbursement areas and the addition to the adopted surgical per diem rate has the impact of demonstrating that the ACIHFG rates are at a significantly higher percentage of comparable Medicare rates than indicated in the study.

COMMENT: Several commenters questioned the standard of "fair and reasonable." A commenter expressed appreciation for recognition through carve outs of unique care required for some types of care but was skeptical that comparative data used to arrive at a reimbursement rate for cases carved out of the guideline will consider the increased expenses of other large teaching institutions in maintaining equipment and having trained staff available. Another commenter stated that "fair and reasonable" is most often the lowest rate of reimbursement that will be tolerated. A commenter questioned whether the "old guideline" now represents "fair and reasonable" even though this guideline was ruled invalid by the courts. A commenter stated that per diem rates in the "old guideline" (§134.400) are "fair and reasonable" as required by statute, stating that hospitals currently serve injured workers because it is in their best interests to do so and this meets the economic definition of "fair and reasonable" because no hospital has decided to refuse workers' compensation patients even though they are free to do so under the law. Commenter went on to state if the hospitals failed to accept workers' compensation inpatients, they would be economically worse off than if they accepted such patients. The commenter also stated that per diem payments, with carve outs and stop-loss, cover the hospitals' incremental costs of serving workers' compensation patients and make a reasonable contribution to the hospitals' fixed costs.

RESPONSE: The Commission agrees that hospitals serve injured workers' because it is their best interest to do so and that is an indication that workers' compensation reimbursement is fair and reasonable. Hospital contracts reviewed included those of large teaching institutions. The determination of what is a fair and reasonable reimbursement for services which are to be reimbursed outside of the ACIHFG or for which a guideline provides for reimbursement at a fair and reasonable rate are determined on a case by case basis. Although the fees contained in the previous ACIHFG (§134.400) are not relevant to this rule, the Commission will respond to the commenter's question regarding that rule. In instances where a health care provider disagrees that the reimbursement paid for a service is fair and reasonable, and an applicable guideline does not provide for a more specific reimbursement, the health care provider can use the Commission's dispute resolution procedures to challenge the amount reimbursed. These statutory standards and objectives do not support commenter's contending that fair and reasonable is the "lowest rate of reimbursement" that will be tolerated. Fair and reasonable reimbursement takes into consideration the interests of all participants in the workers' compensation system by balancing the statutory standards to ensure injured workers receive the quality health care reasonably required by the nature of their injury as and when needed, to achieve effective medical cost control, and to ensure that the fee paid for a workers' compensation patient would not be 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 someone acting on that individual's behalf. Fair and reasonable reimbursement also takes into consideration increased security of payment under the Texas Workers' Compensation Act.

The reimbursement amounts contained in the previous ACIHFG (§134.400) may be determined to be fair and reasonable on a case by case basis based upon an examination of the statutory standards specified for such cases. Fees in the previous ACIHFG (§134.400) were not specifically found by the Court to violate the fair and reasonable standard.

The special considerations addressed by carve outs are discussed elsewhere in this preamble. Finally, as discussed in the preamble elsewhere, the consideration of hospital charges for rate-setting purposes was not utilized because hospital charges do not have a consistent, and rational relationship to either payments accepted by hospitals for services or to hospital costs.

COMMENT: Commenters felt the establishment of the Task Force was a positive step forward. A commenter stated that the Task Force was not given enough time to develop a complete solution. Another commenter recommended the Commission

continue the Task Force meetings to attempt to resolve disputes and questions specific to the ACIHFG.

RESPONSE: The Commission agrees that the establishment of the ACIHFG Task Force was helpful in development of the ACIHFG. The Task Force was useful in presenting various views which were considered in establishing the ACIHFG and, for example, carve outs were incorporated due, in part, to Task Force input. However, there was no consensus in the Task Force on certain main aspects of reimbursement and the Commission believes there would be no further benefit in the creation of another Task Force because there was no indication of any ability of the different interest groups in reaching any consensus on basic areas of disagreement in the rate setting process within a reasonable time period. The Commission has applied its experience and expertise to fair and reasonable reimbursement for the ACIHFG.

COMMENT: Commenter expressed surprise that only 80 hospitals receive 80% of the total workers' compensation reimbursements for acute care inpatient services and questioned whether hospitals may cease taking workers' compensation cases because they are such an insignificant (1.0%) portion of their business. The commenter also stated that the use of managed care contracts is self-defeating in nature, and cannot help but contribute to a further reduction in the access to care for injured workers.

Commenter observed that the hospitals receiving 80% of workers' compensation reimbursement equated to 80 hospitals in 1994 and 77 hospitals in 1995. Twenty- one hospitals present in the list for 1994 were no longer in the list for 1995. Commenter theorized that this demonstrates a decline in the number of hospitals willing to accept workers' compensation patients and questioned whether the reasons for the change had been determined.

A commenter felt that it is reasonable to assume that the fees negotiated by hospitals in managed care contracts will not lead to poorer quality of care, and because the per diem reimbursements are based on those contracted fees, the quality of care should not suffer under the proposed reimbursement rates. Another commenter referred to a survey conducted by The Texas Orthopaedic Association which according to the commenter indicated that 23% of the physicians planned to curtail their workers' compensation services, and questioned what percentage of physicians accept workers' compensation patients and whether this percentage is applicable to hospitals without giving an opinion. Commenter questioned, again without commenting, how many years before this trend compromises care and what would be the impact on the system when fewer facilities and physicians are available and how this would affect injured workers. Commenter questioned but did not comment on what is considered a sufficient number of hospitals to continue providing care to injured workers in Texas and whether a survey was performed to determine if hospitals would curtail or decline injured workers as patients.

RESPONSE: The Commission disagrees that the rates in the ACIHFG will reduce access to quality care for injured workers. The ACIHFG rates must balance the statutory standard that guidelines ensure adequate access to care and quality of care with the statutory standard to achieve effective medical cost control. To do this, the Commission has determined what reimbursements hospitals are contracting for in the open market of managed care. Reimbursement rates which, on the average, will exceed the rates negotiated in these contracts negotiated and voluntarily entered into by the hospitals themselves, and comprising 33.3% of gross hospital revenue, will provide assurance of reasonable and adequate compensation for workers' compensation patients. The managed care rates in the 1994-1995 hospital contracts, on average, significantly exceed, Medicare rates voluntarily accepted by the hospitals and comprising 40% of gross hospital revenue. Therefore, hospitals will be receiving rates, on the average in excess of both Medicare and managed care. Therefore, access to care should not be affected in a negative manner by the ACIHFG. In addition, approximately 7.0% has been added to the average surgical per diem rate in the 1994-1995 per diem contracts, carve outs from the per diem amount have been added to the guideline and the stop-loss threshold has been lowered, increasing reimbursements to hospitals under the rule.

See relevant discussions elsewhere in this preamble, including discussions of relevance and use of managed care contracts, rates adopted, statutory and policy standards, objectives, carve outs, and stop-loss threshold.

The Commission disagrees that the fluctuation in the number of hospitals in the top 80% indicates a decline in the number of hospitals accepting workers' compensation cases. The Commission has no information that any injured worker has been denied access to hospital care and has seen no trend in this direction. The fluctuation between the number of hospitals receiving 80% of workers' compensation reimbursement is attributed to normal, expected fluctuation in cases from one year to another. This fluctuation is insignificant because for example, the difference in reimbursement received by a hospital ranked 80 and a hospital ranked 81 is so small that one additional admission that amounts to a few thousand dollars may be enough to change the hospitals' ranking and potentially reduce the number of hospitals that represent the top 80% of total workers' compensation reimbursement. Change in the number of hospitals in the top 80% does not indicate hospitals are not accepting workers' compensation cases. Commenters question whether workers' compensation is at that point, but does not say whether commenter believes this is so, and why.

In response to the commenter who questioned continued access to hospital care based on a Texas Orthopaedic Association survey, no connection has been made between a survey of orthopaedic doctors who say they will curtail their care of workers' compensation patients and hospitals denying care to injured workers. No data or information has been provided that indicates injured workers have been denied access to hospital care, or have been unable to obtain quality hospital care when needed. No information was provided that the survey was indicative of any access to care problems concerning orthopedic surgeons and the Commission has no credible or verifiable information indicating any such problem. Rather, information indicates an adequate number of orthopedic surgeons for workers' compensation patients. Additionally, no credible or verifiable information in the survey or otherwise was provided or is known

to exist that would correlate the survey results with any access to care issues for hospitals.

COMMENT: Commenters recommended that the ACIHFG be amended to require hospitals to complete box 18 (hour of admission) and box 21 (hour of discharge) on Form UB-92. Commenters felt this information would help carriers make an accurate determination of type of services performed. A commenter also encouraged the Commission to monitor hospital billing to ensure proper completion of the form to the same extent carrier compliance is monitored by TWCC. In addition, another commenter recommended that the Commission mandate that this data be electronically submitted to facilitate monitoring of hospital billing and hospital compliance with completion of these fields.

RESPONSE: The Commission agrees in part. TWCC does monitor forms for proper completion of required fields. Submission of the information in box 18 and box 21 is not currently required for proper completion of the UB-92 form for workers' compensation services because the type of service performed can be determined by the information provided in box 4 "type of service" and box 6 "statement covers period. The TWCC Electronic Data Interface (EDI) section determines which fields of the UB-92 are required to be completed. Commenters suggestion will be forwarded to the EDI section for review. TWCC requires that fields 4 and 6 be completed. The information provided in these fields can determine whether the services performed are inpatient services or outpatient services. In the event that the information in these required fields does not in particular bills, determine the type of services performed, the carrier may request a bill audit to determine admission and discharge times. If the hospital does include this information on the UB-92, the carrier may use the data when auditing the bill. The carriers' bill audit review may include review of admission and discharge times.

COMMENT: Commenter strongly urged that the level of inpatient reimbursement not be increased from reimbursement provided in the previous ACIHFG (§134.400). Another commenter recommended the proposed hospital fee guideline be withdrawn from further consideration.

RESPONSE: The Commission disagrees. See relevant discussion elsewhere in this preamble regarding reasons for adoption of this rule and for the rates and provisions in this rule.

COMMENT: One commenter suggested the rule development process costs money that could be spent on injured workers and has put everyone involved in the position of choosing sides and questioned whether the process has become so adversarial that everyone can no longer work together.

RESPONSE: The Commission agrees in part. The rule development process may be costly, time consuming and at times adversarial; however the Commission is by law to follow the rule development procedures provided in the Administrative Procedure Act. The APA rule development procedures allow the opportunity for all viewpoints to be expressed and evaluated in the rulemaking process. In addition, the Commission appointed a Task Force to obtain additional information and to see if agreement or consensus could be reached by representatives of major participants in the workers' compensation system. However, the task force representatives were unable to reach a consensus on major issues concerning the establishment of reimbursement rates.

The Commission notes that the rulemaking process is costly and time consuming for TWCC as well as for other participants. TWCC does not consider its role, its position on the statute and rules, or the rule as adopted to be adversarial, but notes that many participants appear to have adopted an adversarial position to TWCC as demonstrated, in part, by one or more commenters from an organization who have referred to obtaining authority to file suit to challenge the rule even before the rule is adopted. The Commission notes that hospitals have sued to invalidate Industrial Accident Board and Commission adopted hospital fee guidelines based on a variety of methodologies (cost-based ratio rate, DRG rule and a per diem rule).

COMMENT: Commenter encouraged the Commission to utilize the Medical Advisory Committee (MAC) or another task force to make recommendations for an alternative payment mechanism for inpatient hospital services, due to complexity of the issues.

RESPONSE: The Commission disagrees an alternative payment mechanism is necessary. Beginning in early 1996, the TWCC Medical Advisory Committee (MAC) provided input regarding the revision of the ACIHFG. In April of 1996 the MAC recommended to the Commission a version of the ACIHFG which was proposed in the July 26, 1996 *Texas Register* (21 TexReg 6939). This version, although modified later, was based on the same methodology (use of managed care contract rates) to develop the reimbursement rates adopted in this ACIHFG.

The MAC by statute (Texas Labor Code §413.005) is to advise the Medical Review Division in developing and administering the medical policies, fee guidelines, and utilization guidelines established under the Texas Labor Code, §413.011. The MAC advises the Medical Review Division of the TWCC in the review and revision of medical policies and fee guidelines required under Texas Labor Code §413.012.

In addition, following the public hearing on the previously proposed rule which was held on September 12, 1996, the Chairman of the Commission appointed an ACIHFG Task Force (the Task Force) as authorized by §413.006 and §402.067 of the Act. The Task Force met on six occasions to exchange information and discuss the issues. The Commission staff took the ideas and information provided by the Task Force into consideration in developing its recommendation to the Commission. At the conclusion of the Task Force meetings on January 6, 1996, the members of the Task Force were invited to submit statements to the Commission regarding Commission staff recommendations. The statements submitted illustrated the divergent views regarding the appropriate methods for determining fair and reasonable hospital reimbursements. One Task Force member who has generally been in support of the proposed rule, later in a statement advocated that the per diem rates in the previous ACIHFG should be maintained or lowered. The Commission believes there would be no further benefit to creation of another task force. In developing this adopted new ACIHFG the Commission considered alternate methods of reimbursement for acute care hospital services. See detailed dis-

cussion of alternative payment methods considered elsewhere in this preamble.

The Commission notes that hospitals have sued to invalidate Industrial Accident Board and Commission adopted hospital fee guidelines based on a variety of methodologies (cost-based ratio rate, DRG rule and a per diem rule).

COMMENT: Commenter referred to the proposed ACIHFG and the letter from the TWCC executive director dated February 24, 1997 and contended that these documents indicate that the determination of fair and reasonable fees would be based upon the historical payments under a guideline ruled to be invalid and the commenter questioned if this was the position of the Commission. The commenter also questioned what the position of the Commission is regarding what constitutes a determination by Medical Review as to an order for reimbursement, and whether that means reimbursement in accordance with the now invalid guideline and if this would bar any collection for any re-billing of hospital claims. The commenter also questioned what constitutes a Medical Review order of payment.

RESPONSE: Although the reimbursements based upon the previous §134.400 are not related to the adopted new §134.401, the Commission will respond to the commenter's inquiry. The Commission disagrees that the TWCC Executive Director's letter of February 24, 1997 indicated that the determination of fair and reasonable reimbursement would be based on the previous ACIHFG (§134.400). Neither the adopted ACIHFG nor the Executive Director's February 24, 1997 letter provides that inpatient, acute care hospital services rendered before the effective date of the new rule (134.401), will be reimbursed at the fees specified in the previous ACIHFG (§134.400). For acute care, inpatient hospital services provided prior to the effective date of this adopted guideline (§134.401), the Executive Director's February 24, 1997 letter indicated that reimbursement should be determined in accordance with the following statutory standards described by the term "fair and reasonable

Since the provisions of the Texas Workers' Compensation Act became effective, the Commission has utilized the term "fair and reasonable" to refer to the following statutory standards specified in §413.011(b) of the Texas Labor Code: medical services fees must be fair and reasonable; must be designed to ensure the quality of medical care and to achieve effective medical cost control; may not provide for a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf; and shall consider the increased security of payment afforded by the Workers' Compensation Act. These statutory standards were utilized by the Commission when proposing and adopting this ACIHFG and are utilized by the Commission's staff in issuing decisions in medical dispute resolutions under §413.031 of the Texas Labor Code when the particular medical services either are not specified in a fee guideline of the Commission or the particular guideline indicates that reimbursement shall be at a fair and reasonable rate.

An order of the Medical Review division of the Commission concerning refunds and reimbursements is identified as an order when sent and is issued pursuant to statutory authority such as that found in §413.016 of the Labor Code. Any rebilling by hospital providers as a result of the invalidation of the previous ACIHFG (§134.400) is to be done in accordance with the rules of the Commission, and in accordance with the February 24, 1997 and April 25, 1997 letters of the Executive Director and in accordance with any additional guidance issued. The Executive Director's February 24, 1997 letter does not bar any requested additional reimbursements for resubmitted hospital bills

COMMENT: Commenter questioned what the likelihood is of any hospital receiving adjustments of reimbursement paid under the ACIHFG declared invalid since the letter from the Executive Director excludes claims which should have been timely presented, including those claims for a deviation based upon medical justification. The commenter questioned whether this is expected to have any impact on access to care for injured workers

RESPONSE: Although the reimbursements based upon the previous rule 134.400 are not related to the adopted new §134.401, the Commission will respond to the commenter's inquiry. The Commission disagrees that resubmission of hospital bills as a result of the February 13, 1997 Texas Supreme Court ruling regarding the previous ACIHFG will have any affect on access to care by injured workers. These resubmissions deal with services which have already been rendered. In addition, receipt of fair and reasonable for past services should not affect a hospital's willingness to treat injured workers in the future. The Commission cannot predict what the likelihood is of a hospital receiving adjustments of reimbursements. Each resubmitted case will be considered on its own merits in accordance with the Texas Workers' Compensation Act. Claims for additional reimbursement to hospitals based on medical justification should have been filed within one year from the date of service just as any other such claim, because the Supreme Court ruling did not affect medical justification issues. Hospitals may submit bills for services provided on data beginning with the date previous guideline was declared invalid and the one year period for submitting bills has been extended to allow requests for Medical Dispute Resolution to be filed within a reasonable period of time.

COMMENT: Several commenters indicated general support of the proposed ACIHFG. A commenter stated that this appears be one of the better written rules, that it explained the basis used to develop the rule, the factors considered, conclusion reached and anticipated and responded to several potential questions. Another commenter generally supported the proposed guideline in tracking the mechanisms most commonly used in contracts that are freely negotiated between hospitals and payors.

RESPONSE: The Commission has worked hard to achieve an excellent ACIHFG and appreciates these comments. The Commission agrees.

COMMENT: Several commenters expressed support for the methodology used in developing the ACIHFG. Comments included that the methodology is sound; that commenter agreed with much of the methodology set forth in the preamble and the approach taken; that staff did an outstanding job in putting the guideline together; and that staff should be complimented on

the dedication and persistence taken to balance all the interests in a complex issue such as this one.

RESPONSE: The Commission agrees.

COMMENT: Commenters expressed different views of the statutory standard that TWCC 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. A commenter questioned how and who makes this determination, questioned if this is why averages were used in the development of fees, and if this means the system establishes fees based upon the relative wealth, poverty or economic data of a geographic location. Another commenter believes the proposed rates violate the legislative mandate because: basing fees on the average per diem amounts requires employers to pay rates higher than are being demanded in the market for these services; the 1992 guideline overcompensated the hospitals by a significant amount (medical: 79% of charge; surgical: 60% of charge) and would take several more years of inflation before those amounts require an increase to satisfy the statutory standard; the preamble states the proposed per diem fees are higher than the workers' compensation reimbursements voluntarily contracted for by the hospitals that have workers' compensation clauses in their contracts and therefore violates the statute; when compared with Medicare rates, hospitals receive higher reimbursements for workers' compensation patients than they do for Medicare patients; and the carve outs should have resulted in a lower per diem rate, however there has been no calculation corresponding to the reduction to the average per diem rates that should have occurred when including these carve outs and commenter believed this violated the statute.

RESPONSE: The Commission disagrees that the adopted ACIHFG violates the statutory standard of §413.011. In formulating the hospital fee guideline, the Commission carefully and fully analyzed all of the statutory and policy standards and objectives and all the data and information available and submitted, as well as all comments received. The Commission utilized all of this, and its expertise and experience, to formulate the hospital fee guideline which balances the statutory standards and objectives to ensure injured workers receive the quality health care reasonably required by the nature of their injury as and when needed and to ensure the fee guidelines are fair and reasonable, with the statutory standard to achieve effective medical cost control. The Commission obtained, analyzed and used data relevant to ensuring that the fee paid for a workers' compensation patient would not be 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 someone acting on that individual's behalf, and also took into consideration increased security of payment under the Texas Workers' Compensation Act (Act). If a fee is paid for similar treatment for managed care patients, arguably the fee paid for workers' compensation claimants should be no higher. A recent study provided to the Commission revealed that the standard of living for person's covered by managed care plans is equal to or greater than workers' compensation claimants. The study was performed by Research and Planning Consultants, Inc. and by Dr. Ronald T. Luke, Ph.D. J.D. who provide economic and public policy analyses to numerous public and private sector clients in health care matters including managed care organizations and who provide health cost management services with special attention to workers' compensation medical care cost. The study noted that managed care has become the dominant form of health care coverage for U.S. workers. The study, also, noted that many low skilled and low paying jobs do not carry health insurance benefits and, therefore, workers covered by managed care plans have an equal or higher living standard than workers in general. The study utilized extensive health care literature and information. The Commission recognizes that absolute compliance with this statutory standard is not possible, and believes that the legislature intended §413.011 as a strong policy objective to which the Commission should apply its judgement and expertise when balancing statutory standards and objectives. Absolute adherence to this single provision could adversely affect access to quality health care and fair and reasonable fees which are also statutory criterion. The Commission chose to average the 1994-95 hospital contract rates in order to balance the statutory and policy standards and objectives of the workers' compensation Act.

This guideline is based on managed care contract rates for the year 1994 through September 1995, with an approximate 7.0% addition to the average surgical per diem rate found in the 1994-1995 per diem contracts. It is not based on the previous ACIHFG (§134.400) rates. The comparison of rates in the previous ACIHFG (§134.400) to inflation rates is not relevant to this guideline methodology because the previous ACIHFG was not based on managed care contract rates. (See discussion of inflation elsewhere in this preamble as to how inflation information was considered.)

The inclusion of carve outs in the ACIHFG is part of the balancing of statutory standards and objectives. Carve outs are a method of acknowledging services that are particularly costly in order to ensure fair and reasonable rates for hospitals and to ensure access to quality medical care for injured workers by ensuring that hospitals will continue to treat workers' compensation patients. (See discussion on cost methods of reimbursements and variations of hospital contract fees for why different fees were not set based upon the relative wealth poverty or economic data of a geographic location.) This ACIHFG was not based upon the 1992 ACIHFG and therefore, any over compensation resulting from that guideline was not used as a basis for this new ACIHFG.

COMMENT: Commenter questioned whether the Commissions's conclusion was that since 73.3% of patient revenue comes from third party payors and Medicare, that these revenues are sufficient to cover hospital costs. Commenter questioned whether it was determined how many of these hospitals were nonprofit and if payments to nonprofit hospitals were adjusted to account for endowments, grants, charitable contributions, disproportionate share payments and/or additional federal and state grants. Commenter did not state whether, and why, the Commission should have done so.

RESPONSE: No attempt was made to adjust rates in the contracts based on whether a hospital was nonprofit or not. A hospital's receipt of special subsidies such as disproportionate share payments, charitable contributions, government support and educational subsidies is already accounted for in their

contract rates. These special subsidies are all present in the business environment in which hospitals operate and therefore are accounted for in negotiations of managed care contracts. The Texas Labor Code in §413.011 states that the Commission should ensure guidelines for medical services fees do not provide for payment 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 someone acting on that individual's behalf. To comply with this statutory standard, the Commission, in reviewing and revising §134.400, sought to analyze the hospital reimbursements contained in that rule in relation to reimbursements hospitals were accepting from Medicare and under contracts as payment in full for persons of an equivalent standard of living outside the workers' compensation system for treatment similar to that provided to injured workers. Acute care inpatient hospital services to an injured worker in an HMO/PPO would be paid at these contract rates if the person was injured other than at work.

A commenter from the hospital industry who testified at the hearing on the previous proposed rule §134.400 indicated that hospitals don't contract for rates expecting to lose money.

Because Medicare and third party payor sources account for the vast majority of hospital patient revenue, the reimbursement paid by those payors is a relevant basis for comparison for workers' compensation reimbursement for similar hospital services for persons of an equivalent standard of living. The fact that hospitals on average receive more than 70% of their gross patient revenue from choosing to participate in Medicare and managed care, indicates that the greater of these two rates (*i.e.*, generally managed care rates) certainly achieves compliance with the statutory standards and objectives specified above and elsewhere in this preamble (and the Commission added approximately 7.0% to the average surgical per diem rate found in the 1994-1995 per diem contracts). In addition, the study of Milliman and Robertson, Inc. concerning the comparison of Medicare reimbursements to the previous proposed ACIHFG rates noted why Medicare payments such as a disproportionate share were not considered in that comparison. See detailed discussion regarding case complexity, the Milliman and Robertson study, and the standard of living study elsewhere in this preamble.

COMMENT: Commenter believed a statement from the preamble that "94.8% of the per diem rates for the same hospital were either reduced, stayed the same, or increased by less than 10%" was ambiguous, and questioned what percent stayed the same, declined and increased less than 10%.

RESPONSE: The Commission agrees that the figures could be clarified. The 94.8% figure includes a few contracts that appeared in either the 1995 group or the partial 1996 group of contracts received but not both. These few contracts have no means of comparison and should have been excluded from the 94.8% statistic. With this correction, the percentages are as follows: 12.5% remained the same; 35.4% decreased; 36.99% increased less than 10%; 9.82% had no means for comparison; and 5.2% increased more than 10% (total is slightly less than 100% due to rounding).

COMMENT: Some commenters felt the proposed per diem rates were too low, do not cover costs, and are grossly inadequate. While some commenters felt all the per diem rates were inadequate, some expressed the opinion that the surgical rates which according to the commenter comprise 80% of the workers' compensation admissions and/or the ICU rates were particularly low to cover the complexities associated with a workers' compensation admission. Commenters stated that surgical admissions comprise a high percentage of the workers' compensation admissions and that the proposed surgical rates do not cover the expenses for treating injured workers. THA submitted a financial analysis and stated that the analysis showed the proposed per diem rates will not cover the estimated costs of providing inpatient services to workers' compensation patients, with most of the losses occurring on surgical admissions. THA also expressed the view that the stop-loss provision and carve outs included in the proposed rule will reduce but does not eliminate losses on workers' compensation surgical cases and that decreased lengths of stay resulted in the costs of services being compressed into a shorter period of time. THA also contended that hospitals will make a small gain on medical admissions but because medical constitutes only 27.0% of workers' compensation admissions, those gains do not off set the loss on surgical admissions. Commenter stated that based on a TWCC analysis the average length of stay has decreased from 4.4 in 1993 to 3.2 in 1996 and therefore, hospital payment rates will be set too low.

RESPONSE: The Commission disagrees that the proposed per diem rates are too low and will not cover hospital costs. The Commission considered alternative methods for reimbursement and found cost-based methodologies to be questionable as explained in the following sentences. The Texas Hospital Association's financial analysis which shows the proposed per diem rates will not cover hospital costs is based on the use of a cost-based reimbursement system. This system is based upon data from THA's own proprietary data base and the TWCC database. The cost calculation on which THA's model, as well as other cost-based models, was derived, use hospital charges as its basis. 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 107.0% from 1992 to 1996 and by 65% from 1993 through 1996, whereas for those 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. Therefore, under a so-called cost based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs.

In order to determine what reimbursements were being paid to hospitals outside the workers' compensation system, the

Commission sought a source of accurate, verifiable data. The Texas Department of Health, Bureau of State Health Data and Policy Analysis' 1996 report from its annual survey of hospitals, revealed that in 1995 Texas acute care hospitals received 40% of their gross patient revenue from Medicare, and 33.3% from third party payors. Because these sources account for the vast majority of hospital patient revenue, the reimbursements paid by these payors is a relevant basis for comparison between workers' compensation reimbursements and these other major reimbursement systems for similar hospital services for persons of an equivalent standard of living, and for establishing fair and reasonable fees for workers compensation. The fact that hospitals on average receive more than 70% of their gross patient revenue from choosing to participate in Medicare and managed care, indicates that the greater of these two rates (*i.e.*, generally managed care rates) certainly achieves compliance with the statutory standards and objectives specified above and elsewhere in this preamble. In addition, at the public hearing on the previous proposal of the ACIHFG, testimony by hospital representatives admitted that hospitals do not knowingly negotiate contract rates for any type of service which will cause the hospitals to lose money in providing that service.

The hospital contracts and summaries were analyzed to determine what types of services and/or supplies were reimbursed outside ("carved out of") the per diem rates in the contracts. All carved out items and services that are in any of the 1994-95 hospital contracts (even those in less than 1.0%) and are applicable to typical workers' compensation cases are included as carve outs in this rule, and this increases reimbursement.

Other provisions which serve to increase reimbursement include a stop-loss provision, the threshold for which and the percentage reimbursement for which was determined from the 1994-1995 hospital contracts.

In response to the commenter's suggestion that decreased lengths of stay be considered in the reimbursement methodology, a study by actuaries of Milliman and Robertson, Inc. utilizing data maintained by that national actuarial firm for managed care hospital stays, incorporated assumptions of an overall average length of stay of 3.3 days with an average length of stay for medical and surgical admissions of 3.9 days. These lengths of stay compare with 1995 data of the Commission of an overall length of stay of 4.8 days for medical cases and 3.5 days for surgical cases. Therefore, unlike Medicare patients with significantly longer lengths of stay, any differences in lengths of stay between managed care patients and workers' compensation patients were not substantial as reviewed in the Milliman and Robertson study. Hospital contracts and summaries of those contracts reviewed by the Commission did not include average lengths of stay for cases under such contracts, but the Commission has not received or been able to locate any source indicating that the lengths of stay are substantially different for the managed care patients. Therefore, it can be assumed that managed care contracts are negotiated with this factor in mind and that the rates in the managed care contracts are sufficient reimbursement.

See also, relevant discussions elsewhere in this preamble, including discussions of data, Medicare rates comparison, use of managed care contracts, complexity of cases, steerage, methods of reimbursement, per diem chosen, per diem rates adopted, tiered per diems, stop-loss, carve outs, inflation and THA's alternative proposal.

COMMENT: Commenter expressed the opinion that using an average of the reimbursements found in managed care contracts to establish workers' compensation reimbursements is not in keeping with the statute that mandates the guidelines may not provide payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living. Commenter stated the results of the proposed guideline exclusion of carve outs and other provisions would be reimbursements even above the median or average rate and recommended lowering the percentile or using the bottom 25 percentile rather than the median. Commenter felt that the Commission should focus on the lowest rates offered in the managed care contracts, not on the average and have a much lower rate of in reimbursement.

RESPONSE: The Commission disagrees that the lowest rates offered in the managed care contracts must be or should be used as a basis for the ACIHFG. The Legislature in Texas Labor Code §413.011 states that the Commission establish fees which do not provide for payment of a fee in excess of the fee charged and paid for similar treatment of an injured individual of an equivalent standard of living or by someone acting on that individual's behalf. This standard does not stand alone. The Commission is additionally required to establish guidelines which balance the various interests in the workers' compensation system by ensuring that medical services fees are fair and reasonable, that injured workers receive quality health care reasonably required by the nature of their injury as and when needed, and that effective medical cost control is achieved. Average per diem rates in the 1994-1995 hospital contracts were utilized rather than the lowest per diem rates because most rates were closer to the average than to either the higher or lower rates, because averaging minimizes the effects of outliers, because the lowest rates may not accurately reflect hospitals economic factors for all the hospitals with greater rates and because a reimbursement based on an average rate will be a greater incentive for maintaining access to quality health care than use of the lowest rates. An additional approximate 7.0% was added to the average surgical per diem found in the 1994-1995 per diem contracts, to ensure access to quality health care and as an additional protection to ensure fair and reasonable rates for surgical cases.

In formulating the hospital fee guideline, the Commission carefully and fully analyzed all of the statutory and policy standards and objectives and all the data and information available and submitted, as well as all comments received. The Commission obtained, analyzed and used data relevant to ensuring that the fee paid for a workers' compensation patient would not be in excess of the fee charged for similar treatment of an injured individual's behalf, and also took into consideration increased security of payment under the Texas Workers' Compensation Act (Act). If the fee is paid for similar treatment for managed care patients, arguably the fee paid for workers' compensation claimants should be no higher, as argued by commenter. However, the Commission recognizes that absolute compliance with this statutory standard is not possible, and believes that the legislature intended §413.011 as a strong policy objective to which the Commission should apply

its judgment and expertise when balancing statutory standards and objectives. Strict adherence to this single provision could adversely affect access to quality health care and fair and reasonable fees which are also statutory criterion.

COMMENT: Some commenters suggested using a tiered per diem reimbursement scheme for surgical cases. Commenter suggested in the alternative, a case payment method. Commenter supported a tiered per diem as long as it did not result in workers' compensation paying more for a surgical admission than other payors. Recommendations related to using a tiered per diem scheme include: ensuring that the entire payout for the hospital stay does not exceed the cost of an equivalent stay under the managed care contracts; if the new guideline includes a tiered per diem, the proposed carve outs, which are based on the most common carve outs in the 1994-1995 hospital contracts should be narrowed; and that reimbursement for surgical services for the first two days be slightly higher than $1,045, and slightly less than that amount for subsequent days to encourage shorter lengths of stay where medically appropriate while still ensuring fair and reasonable reimbursement. A commenter expressed the opinion that using a tiered per diem is not consistent with the goal of basing the new guideline on the most common practice in negotiated contracts as a majority of contracts with per diem do not have tiering. Another commenter felt that tiered per diem rates is a way to deal with losses hospitals would incur for surgical admissions under the proposal. Commenter suggested that the Commission would not consider using a tiered per diem approach because it is not in the managed care contracts.

RESPONSE: The Commission agrees that using a tiered per diem is not consistent with the methodology of basing the new guideline on the most common practice in negotiated contracts.

The Commission disagrees that using a tiered per diem for surgical cases or a case payment method should be used for the ACIHFG. The Commission carefully and fully considered tiers. All data and information the Commission has or which was submitted to the Commission were considered. Analysis of the 1994-1995 hospital contracts and summaries received by the Commission revealed that only 97 of the 1,321 per diem contracts contained some form of tiered per diem for surgical admissions. A per diem rate is said to be "tiered" when there is a difference in reimbursement based on which day of the hospital stay is being reimbursed. Although tiering surgical per diem rates may have some merit based on the allegation of THA and others that more hospital resources may be expended on the day of surgery than on the following days, the Commission chose not to use tiered per diems in this ACIHFG because, in the 1994-1995 hospital contracts and summaries, tiering was not the predominant method of utilizing per diem reimbursements. The Commission has no information to indicate that the per diem rates in the non-tiered managed care contracts do not represent services with various lengths of stay and various types and severity of injury/illness, and, in fact, believes that they do. As only 4.0% of the 1994- 95 hospital contracts carve out trauma, consideration of front loaded expense and severity should have been factors in negotiating the contract and thus in their negotiated and agreed per diem rates, and thus in the per diem rates adopted by the Commission. However, if there is front loaded expense and severity not accounted for in the managed care contracts, other provisions in the ACIHFG as adopted by the Commission will compensate for this, as they increase actual reimbursement. (See discussions elsewhere in this preamble regarding the exemption of certain small hospitals in subsection (a)(1), stop-loss, carve outs, and outpatient services.) In addition, any need for greater reimbursement for the first day for additional services is balanced by any need for lesser reimbursement for fewer services during the later part of a length of stay. In other words, the uniform per diem averages reimbursement needs for each day of the length of stay. The vast majority of 1994- 95 hospital contracts utilize a uniform per diem rate for each day of a surgical admission. Finally, because the average length of stay for surgical cases has declined on the average to be similar to surgical lengths of stay for managed care contracts, there was no need for a tiered per diem as a device to limit the lengths of stay. Case payment methods such as using DRGs were rejected as a method of reimbursement in the ACIHFG. See the detailed discussion of the reasons for this elsewhere in this preamble. The Commission therefore concluded that tiered surgical rates are not necessary for a rate to be fair and reasonable, or to ensure access to quality health care.

COMMENT: A commenter gave an example as to why the proposed reimbursement for a surgical admission is not enough to cover the costs of a workers' compensation patient. Commenter stated the first day of a hospitalization could easily result in charges of $5,000 or more.

RESPONSE: The Commission agrees the situation described by the commenter is plausible. However, the commenter's example, is just as plausible for patients under managed care. Therefore, this would have been taken into consideration when negotiating reimbursements for managed care contracts. Because the Commission utilized managed care contracts to establish workers' compensation rates, this situation has been accounted for. In addition, the guideline adds approximately 7.0% to the average surgical per diem found in the 1994-1995 per diem contracts, and includes provisions which carve out very high cost cases and allow reimbursement at a fair and reasonable rate.

The Commission considered alternative methods for reimbursement and found cost-based methodologies to be questionable. The Texas Hospital Association's financial analysis which shows the proposed per diem rates will not cover hospital costs is based on the use of a cost-based reimbursement system. This system is based upon data from THA's own proprietary data base and the TWCC database. If the commenter was implying that charges are closely related to costs, the Commission notes that the cost calculation on which THA's model, as well as other cost-based models, was derived utilized hospital charges as its basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs. A study by Commission staff comparing hospital charges and payment amounts revealed substantial and non-uniform differences between charges and what is being accepted by hospitals as payment, and a 107.0% increase in surgical hospital admission charges per the TWCC billing database in the same time period in which the Consumer Price Index (CPI) inflation rate was 16% and the Medical Care Services section of the CPI inflation rate was 29%. Therefore,

under a so-called cost based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory standards and objectives of achieving effective medical cost control and not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. Finally, as explained in response to other comments and elsewhere in this preamble, the per diem rates (which include an additional 7.0% for surgical cases), balance any more costly services the first day with any less costly services during the additional days of the length of stay for patients.

See also, relevant discussions elsewhere in this preamble, including discussions of data, Medicare rates comparison, use of managed care contracts, complexity of cases, steerage, methods of reimbursement, per diem chosen, per diem rates adopted, tiered per diems, stop-loss, carve outs, inflation and THA's alternative proposal.

COMMENT: One commenter felt that since 80 hospitals received 80% of the admissions for injured workers, that these hospitals are facing a far greater financial penalty by handling these cases than the other 400 plus hospital facilities.

RESPONSE: The Commission disagrees that the top 80 hospitals are penalized because they handle 80% of workers' compensation cases. The hospitals that received 80% of the workers' compensation dollars in 1995 were the hospitals that submitted managed care contracts. The analysis of their managed care contracts reflects what acute care hospitals that receive the largest total reimbursement from the workers' compensation system are willing to accept for payment of care in non-workers compensation health care systems. Some of these hospitals are entering into managed care contracts for rates lower than those proposed in this guideline; this illustrates that these hospitals are not being financially penalized by the adopted rates. Establishing the reimbursement in the ACIHFG based on the average of what these hospitals are voluntarily negotiating in the open market for similar services (plus approximately 7.0% for surgical cases) cannot be viewed as penalizing these hospitals, especially when carve outs, and stop-loss increase reimbursement. Participation in the workers' compensation system is voluntary. Finally, the fair and reasonable rates for certain small hospitals exempted under subsection (a)(1) may or may not result in greater or lesser reimbursement than the per diem amounts. This is due to the case by case decisions made by insurance carriers and, when appealed, the medical dispute resolution process. See, also, relevant discussion elsewhere in this preamble, including discussion of data, Medicare rate comparison, use of managed care contracts, complexity of cases, steerage, methods of reimbursement, per diem chosen, tiered per diem, stop-loss, carve outs, and inflation.

COMMENT: Commenter stated that there is a significant surplus (less than half of the licensed beds in the state are filled on any given day) of inpatient hospital capacity in Texas and that hospitals are therefore willing to provide services as long as the incremental revenue is expected to cover the incremental costs of the patient and make some contribution toward fixed costs. Commenter believes that hospital overbuilding is not a valid reason for TWCC to set fee schedules that result in employers paying for this overinvestment.

RESPONSE: The Commission disagrees that ACIHFG per diem rates have been set so as to pay for any over investment by hospitals as the result of overbuilding. The Commission has not utilized a cost-based system for the reasons specified elsewhere in this preamble. Rather, the Commission has used the average per diem rates in managed care contracts negotiated between hospitals and payors (plus approximately 7.0% for surgical cases). Per diem rates reflect economic forces in the market place, including but not limited, investments by the various hospitals in buildings. The Commission feels the use of these market-determined rates will not artificially encourage or discourage building investments by hospitals. The Commission agrees the significant number of empty hospital licensed beds in Texas is a factor that has been considered in negotiating managed care contracts and contributes to hospitals' willingness to provide services to beneficiaries of managed care contracts as well as injured workers in the workers' compensation system at competitive rates.

COMMENT: Commenter questioned whether any comparisons were performed to determine if the reimbursement inducements in the ACIHFG are related to existing contracts the hospitals may have with insurance companies or employer groups. Commenter did not comment on whether or why the Commission should have done such comparison.

RESPONSE: It is unclear what the commenter meant by "existing contracts". Managed care contracts were received from hospitals which came in effect for dates of services on or after January 1, 1994 through October 1, 1995. When the contracts were reviewed, an effort was made to determine, based on the language in the contracts, what factors influence the rates hospitals were willing to accept. All carved out items and services that are in any of the managed care contracts (even those in less than 1.0%) and are applicable to typical workers' compensation case are included as carve outs in this rule and increase reimbursement. Reimbursement methods for the carve outs are based on the 1994-1995 hospital contracts. Other provisions which serve to increase reimbursement include the addition of approximately 7.0% to the surgical per diem rate, a stop-loss provision, the threshold for which and the percentage reimbursement for which was determined from the managed care contracts. If "existing contracts" refers to more recent contracts, the Commission notes that many of the contracts for the period of October 2, 1995 through October 1, 1996 maintained the same provisions including the same rates.

See also, elsewhere in this preamble discussion on carve outs and stop-loss provision.

COMMENT: Commenter challenged the conclusion in the preamble to the proposal that the utilization of per diem contracts is increasing and that this is sufficient reason to conclude that per diem reimbursements are sufficient when based on broad categories of services. Commenter asked if managed care contracts were compared to hospital admissions to determine utilization patterns without commenting on whether or why the Commission should have done so.

RESPONSE: The Commission disagrees that the utilization of per diem contracts by hospitals is not sufficient reason to set per diem reimbursements in the ACIHFG. The per diem method was chosen for §134.401 because the per diem method of re-

imbursement was the most commonly used (51.5%) method for inpatient hospital reimbursement in the hospital contracts, because of the disadvantages of other payment methods, because this is the method used in rule §134.400 for workers' compensation inpatient hospital reimbursement and therefore allows greater continuity in administrative billing procedures, and because the per diem method has advantages in administrative convenience in billing and review of bills. The Commission's analysis of managed care contracts indicates that in the open market where hospitals have a choice, per diem contracts constitute the majority of negotiated reimbursement methodologies. Industry wide acceptance of per diem rates is evidence that per diem methodology is appropriate for the ACIHFG. Preliminary analysis of the contracts for the period October 1995 through October 1996 shows little or no change in the average per diem reimbursement rates and shows that the total number of contracts that have per diem rates is increasing. 52.6% of the hospitals have more per diem contracts than before. The managed care per diem contracts set separate rates for medical services, surgical services, and intensive care unit services or for combined medical/surgical. The per diem managed care contracts do not break the fees down into smaller segments of treatments and services, or into a larger number of categories. Rather, the one inclusive fee for each of the medical, surgical, and ICU categories of service in the managed care contracts shows that it is appropriate to have one fee for medical, one fee for surgical, and one fee for ICU/CCU for workers' compensation. See elsewhere in this preamble for further detail of the Commission's analysis of managed care contracts and use of per diem reimbursement. The Commission lacks the resources to compare managed care contracts to hospital admissions to determine utilization patterns, and does not think this comparison is necessary because as indicated by hospital members of the ACIHFG Task Force, utilization patterns are considered in the negotiation of managed care contracts.

COMMENT: Commenter stated there appears to be no effort on the part of the Commission to consider, analyze, or recognize the discounts or deviations applied to workers compensation fee schedules in the managed care contracts applicable at the time these managed care contracts were entered into by the hospitals; and since many of these discounts from fee schedules are for a limited patient population, which the may or may not be related to workers' compensation, and may only present a limited utilization of a specific hospital's services, the Commission appears to be recommending fees below what is termed fair and reasonable.

RESPONSE: The Commission disagrees. The presence of hospital contracts that include discounts from the previous TWCC fee schedule indicates that hospitals are willing to accept as fair and reasonable reimbursement rates below the 1992 ACIHFG. This further supports the sufficiency of the adopted rates which overall provides an increase in reimbursements for acute care inpatient services. In addition, the overall use of managed care contracts in Texas (*i.e.*, 33.3% of total gross patient revenue from third party payors in 1995 with an additional 40% being for Medicare patients) indicates that most of the working population in Texas are covered by such contracts. See, also, relevant discussions elsewhere in this preamble, including discussion of data, Medicare rate comparisons, use of managed care contracts, complexity of cases steerage, methods of reimbursement per diem chosen rates, stop-loss, carve outs, and inflation.

Furthermore, the suggestion to consider, analyze or recognize discounts or deviations is irrelevant to the development of the adopted ACIHFG since those discounted rates not specified as per diem rates, were not included in the calculation of average managed care contracts per diem rates.

The commenters assertion that the discount from the previous TWCC fee schedule applies to a limited patient population is incorrect in that these discounts apply to all workers' compensation patients. Workers' compensation patients have access to all hospital services and utilization is not limited.

COMMENT: Commenter believed that by using reimbursements set in the managed care contracts the ultimate reimbursement is left in the control of the hospitals, a strategy rejected in the preamble. Commenter questioned why discount from fees is appropriate in a managed care contract but not appropriate in developing fees based upon managed care contracts.

RESPONSE: The Commission disagrees that basing the ACIHFG on fees in managed care contracts places the ultimate reimbursement in the hands of the hospital in the same way a discount from charge methodology would. Managed care contracts are a result of negotiations between the provider and the insurance carrier. These contracts therefore take into consideration the market conditions from the view points of both parties to the contract. The hospitals are not in full control of contract rates as they are in control of charges. The discount from charge method was found unacceptable for workers' compensation 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. In addition it provides no incentive to contain medical costs. The per diem method was chosen for the ACIHFG because of the disadvantages of other payment methods (discussed elsewhere in this preamble), because the per diem method was the most common method used in the hospital contracts, because per diem reimbursement was the method used in the previous ACIHFG (which allows greater continuity in administrative billing procedures), and because the per diem method has advantages in administrative convenience in billing and review of bills.

See, also, relevant discussion elsewhere in this preamble, including discussion of use of managed care contracts, cost-based methodologies, and choice of per diem method.

COMMENT: Commenter questioned whether it is appropriate to average contract rates and per diem rates for Medicare but to discount and not consider nor give any weight to other essential elements critical to any comparison of the data.

RESPONSE: Medicare rates were considered but were not utilized as the principal basis of per diem rates in this ACIHFG. Medicare rates were used for comparison purposes and indicate that reimbursements for Medicare patients paid at rates often lower than these ACIHFG rates, have been accepted by hospitals even when more complex and costly services may be required. It is unclear what "essential elements" the commenter is referring to. The Commission has expended

extensive efforts in considering other elements including those presented in the Hospital Task Force. The Task Force discussion resulted in the inclusion of substantial carve outs, and the lowering of the stop-loss threshold from the previous ACIHFG (§134.400). Other elements considered included: 1) the amounts currently accepted by hospitals as payment in full under contracts for acute care inpatient services and for Medicare patients when setting the per diem rates; 2) non-workers' compensation data; 3) the security of payment in the workers' compensation system resulting from the absence of co-payments and deductibles which are included in some managed care contracts; 4) reimbursement to acute care hospitals which is sufficient to induce a sufficient number of hospitals to continue in the system to ensure access to quality medical care for injured workers in Texas. The Commission is to establish guidelines which balance the various interests in the workers' compensation system by ensuring that medical services fees are fair and reasonable, that injured workers receive quality health care reasonably required by the nature of their injury as and when needed, and that effective medical cost control is achieved and this rule does that based on Commission expertise and experience

The Commission chose to average the per diem managed care contract rates in arriving at the rates in the ACIHFG to balance the statutory and policy standards and objectives of the Workers' Compensation Act. Averaging minimizes the effect of outliers in the data because most rates were closer to the average than to either the higher or lower rates, because the lowest rates may not accurately reflect hospital economic factors for all the hospitals with greater rates and because a reimbursement based on an average rate will be a greater incentive for maintaining access to quality health care than use of the lowest rates. However, out of an abundance of caution to ensure access to quality health care and as an additional protection to ensure fair and reasonable rates for surgical cases, the Commission increased the surgical reimbursement rate in the adopted ACIHFG from the per diem contract average rate of $1,045 per day to $1,118 per day. See detailed discussion elsewhere in this preamble.

COMMENT: Commenter questioned why weighted averages and median charges were not considered for this guideline, but they were utilized in other fee guidelines. Commenter did not comment on whether and why the Commission should have used these methodologies.

RESPONSE: Charges, including median charges, were not utilized in development of the ACIHFG because each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs. This is exemplified by a study by Commission staff which indicated that charges for surgical hospital admissions (per TWCC billing database) increased by 107.0% from 1992 to 1995 and by 65% from 1993 through 1996, whereas for those 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.

Weighted averages were not used because of the difficulty in establishing appropriate weighting methodologies. Weighted averages were not necessary because the distribution of contract per diem rates was concentrated around the average rate. Similar methodologies are not necessarily appropriate for every guideline. Considerations must be given to many factors when developing guideline methodology including data available to be analyzed, market practices and trends, as well as statutory standards and objectives.

COMMENT: Commenter expressed concern that the rule does not make a provision for increasing rates over time to account for the effects of inflation on hospital costs

RESPONSE: The Commission disagrees that an inflation factor should be included. Inflation factors are not the same each year, and in fact they can indicate decreases as well as increases in costs. Such factors cannot be accurately predicted into the future. It would therefore be unwise to try to predict future inflation factors and provide for an automatic predetermined future adjustment in the reimbursement rates provided in the ACIHFG.

The hospital reimbursements in the new ACIHFG are sufficient to account for the inflation of 12% reflected in the CPI for the period from 1993 to 1996, and the new ACIHFG's estimated 17.4% increase over rates contained in the previous ACIHFG (which percentage does not account for any possible increased reimbursement due to the exemption of certain small hospitals under subsection (a)(1)) is just under the Medical Care Services CPI of 18% for the period 1993 to 1996.

In addition, preliminary analysis of approximately 300 newer per diem managed care contracts for the period October 1995 through October 1996, which have been reviewed by the Commission indicates that with the exception of a few contracts, there was little or no change in the average per diem reimbursement rates ($863 medical per diem, $1,015 surgical per diem, and $1,537 ICU per diem) when compared to the average per diem rate of the contracts and summaries obtained earlier by the Commission. This preliminary analysis also indicates the total number of contracts that have per diem rates is increasing. In addition, a comparison of the newer contracts to the earlier contracts for the same hospital(s) indicates that 52.6% of these hospitals have more per diem contracts than before. A comparison of the averages of the newer contract rates to the earlier contract rates for the same hospital(s) shows that of the 692 per diem rates in the newer contracts 84.96% of the per diem rates were either reduced, stayed the same, or increased by less than 10%. Based on the comparison to inflation rates and the rates in the more recent contracts, the Commission concluded that an overall future inflation adjustment for the adopted rates is not necessary to ensure fair and reasonable rates for these hospitals or to ensure access to quality health care for injured workers by ensuring that hospitals will continue to treat workers' compensation patients. However, out of an abundance of caution to ensure access to quality health care and as an additional protection to ensure fair and reasonable rates for surgical cases, the Commission increased the surgical reimbursement rate in the adopted ACIHFG from the per diem contract average rate of $1,045 per day to $1,118 per day. See detailed discussion elsewhere in this preamble.

The Center for Health Care Industry Performance Studies' *1996-1997 Almanac of Hospital Financial and Operating Indicators* (as reported in *Medical Benefits*, October 30, 1996) reports that U. S. hospitals in high managed care markets realized significant improvements in profitability during 1995 and are more profitable than hospitals that operate in lower managed care markets. In addition, the *Almanac* reports that profitability in the hospital industry reached a five-year high in 1995. This publication presents information on hospital performance in 1995 and reviews performance measures for the past five-year period.

The U S. Prospective Payment Assessment Commission, a federal advisory panel, voted in January of 1997 to recommend no change in Medicare payment rates for hospitals. *N.Y. Times*, January 19, 1997. The panel concluded that hospitals had effectively controlled their costs, so that existing Medicare rates were generally adequate. Spokesmen for the advisory panel indicated that its recommendation would not harm the quality of health care or access to care for beneficiaries in the Medicare program. They indicated that Medicare hospital costs have been declining while Medicare payments have increased at a moderate rate, favorably affecting the profitability of the hospitals' Medicare business. In fact, the advisory panel's figures show that the operating expense for each Medicare patient has actually declined in the three year period of 1993 through 1995. The article states that the cost of medical care, as measured by the CPI, rose last year by just 3%, the smallest amount in three decades, and the first time since 1980 that medical prices rose less than the overall index. In addition, the article reports that economists told Congress last month that the CPI tends to overstate inflation. The advisory panel's recommendations and data and the statements regarding CPI inflation figures and medical care inflation provide additional indicators of why an inflation factor is not justified for the average, managed care contract rates existing in Texas through October of 1995.

All of these indicators support not including an overall future inflation factor in the adopted rates of the ACIHFG.

COMMENT: Commenter questioned the Commission s conclusion that because the consumer price index (CPI) and hospital charge data were not comparable, hospital charges were not valid indicators of hospital costs. Commenter asks if this is a clear indicator of the need for hospitals to try and cost shift through increased charges because 73.3% of their business may well be at or below costs. Commenter asks if this is a factor in the increased consolidations, mergers, acquisitions, and the reduction in the number of non-profit hospitals. Commenter did not state a position on the subject or comment on whether or why the information requested would be relevant to the proposed ACIHFG.

RESPONSE: The Commission disagrees the workers' compensation system should compensate for inadequate or lower reimbursements in other systems. In addition, the workers' compensation system should not compensate for hospitals that are inefficient or poorly managed. The Workers' Compensation Act provides that guidelines for medical service fees may not provide for a 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 someone acting on that individual's behalf. Workers' compensation fees are not to subsidize the provision of non- workers compensation medical care, including that which is subject to managed care. (Research Papers of the Joint Select Committee, September 1988, Chapter 6). The Commission disagrees with the commenters conclusion that 73.3% of hospital business is at or below cost. The fact that hospitals receive the vast majority of their gross patient revenue from choosing to participate in Medicare and managed care indicates that reimbursements received from those payors are sufficient to cover the hospitals' costs. At a recent hearing for the Texas Healthcare Information Council regarding the

Hospital Discharge Data Rule, representatives from Columbia Mainland Medical Center, Columbia Doctor's Regional Medical Center and Park Plaza Hospital testified that hospital charges are basically meaningless in current managed care environment. Therefore the Commission is correct in not utilizing hospital charges when setting ACIHFG reimbursement rates. As discussed elsewhere in detail in this preamble, hospital charge data is not a valid indicator of hospital costs. In addition, as a commenter at the public hearing on the previous proposal of this guideline indicated, hospitals do not intentionally negotiate contract rates which would cause them to lose money on a per case basis. Therefore, basing hospital rates on negotiated contract rates takes into consideration hospital costs.

The Commission has not reviewed data or information which would indicate that hospital consolidations, mergers, acquisitions, and reduction in number of non-profit hospitals result from hospitals providing services at below cost. Rather, recent data in the Center for Health Care Industry Performance Studies' *1996-1997 Almanac of Hospital Financial and Operating Indicators* (as reported in *Medical Benefits*, October 30, 1996) indicates that U. S. hospitals in high managed care markets realized significant improvements in profitability during 1995 and are more profitable than hospitals that operate in lower managed care markets. In addition, the *Almanac* reports that profitability in the hospital industry reached a five-year high in 1995. This publication presents information on hospital performance in 1995 and reviews performance measures for the past five-year period.

If the Medical Care Services CPI is accepted as a valid indication of inflation in costs to provide medical services, then the fact that the charges for hospital admissions increased at a vastly greater rate than the CPI indicates that the increase in hospital charges is largely attributable to factors other than inflation in costs. See discussion elsewhere in this preamble regarding the comparison of inflation rates versus the increase in hospital charges.

See also, relevant discussions elsewhere in this preamble, including discussions of case complexity and case mix and of an additional approximate 7.0% in the surgical per diem rate.

COMMENT: Commenter agreed with the recognition that the previous per diem rate for medical cases was inadequate and was accordingly raised from $600 to $870 per day.

RESPONSE: The Commission agrees that an increase in per diem rates for medical cases was warranted and has incorporated that increase into the ACIHFG. The Commission has been provided no data or information which would support

that the per diem rates in the previous ACIHFG when it was adopted in 1992, were inadequate

COMMENT: Commenter agreed that managed care contracts are an appropriate guide to setting the fee schedule, but felt that a hospital's net revenue as a percentage of gross revenue on Medicare hospital bills should be used as an additional guide to setting the per diem rates. Commenter agreed with crafting a guideline that reflects as closely as possible what the hospitals are negotiating and accepting in the open market, but the commenter also believed that the more services carved out of the per diem rate, the lower the per diem rate must be and the commenter is not convinced the proposed guideline follows this principal

RESPONSE: The Commission disagrees with the commenter's recommendation that a hospitals' Medicare net and gross revenue be used as an additional guide to setting per diem rates. Hospital contracts provide the most accurate, verifiable information of the current hospital service market and thus the most relevant information regarding fair and reasonable rates, access to quality health care, cost control, and fees paid for similar treatment by persons of an equivalent standard of living. Medicare rates are not determined by voluntary negotiation and largely involve non-working elderly patients who require longer lengths of stay and a higher co- morbidity.

The Commission disagrees with the commenter's recommendation to lower the per diem rates because of the carve outs that are included in the ACIHFG. The services and supplies chosen for carve out require significantly more costly and complex services which increase hospital reimbursement and will ensure fair and reasonable rates for hospitals and access to quality care for injured workers. Carved out services and supplies are based on managed care contracts. The statutory standards and objectives for cost control and that the guideline not pay in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living must be balanced with the statutory standard for reasonable access to quality health care. Carve outs are a way of ensuring that this balance is maintained. The Commission believes that the effect of carve outs should be watched and analyzed as experience with the new ACIHFG is gained. Data, information, and input will be obtained and reviewed, and action taken to adjust the fees and other aspects of the rule as appropriate.

COMMENT: Commenter questioned why the Medicare cost report adjustments were not included and why diagnosis and procedures provided to Medicare patients were excluded in the analysis for setting reimbursements in this guideline. Commenter did not comment on whether or why the Commission should have included such information.

RESPONSE: Reimbursements in the ACIHFG were set using averages from per diem rates found in the 1994-1995 hospital contracts for each category of medical, surgical, and ICU, with the addition of approximately 7.0% to the average surgical per diem rate found in the 1994-1995 per diem contracts. For further discussion on the reasons why the Commission chose to look at managed care contracts and use per diem reimbursements from those contracts as a basis for the adopted rule see discussions in other parts of this preamble.

The actuarial study described in the proposal preamble used Medicare rates for comparison purposes and to indicate that Medicare rates, which are often lower than rates in the ACIHFG, have been accepted by hospitals even when more complex and intensive services may be required. Rates were not set based on Medicare rates. Cost report adjustments are not relevant to managed care contracts because Medicare cost adjustments are part of the Medicare reimbursement system. As such, it applies only to Medicare rates and are not applicable to managed care contract rates. Therefore Medicare cost adjustments were not considered in the development of reimbursements set in this guideline. If the commenter's reference to "diagnosis and procedures provided to Medicare patients" is a comment on why a Medicare DRG methodology was not used, see the discussion elsewhere in this preamble on why the DRG methodology was not utilized.

COMMENT: Commenter questioned why no inquiry was made to determine the causes of the variances in the managed care contracts and the commenter questioned why the Commission did not research into this in greater depth. Commenter suggested that there are other motivating factors which must be given equal weight and that this wide variance indicates that any attempt to use an average would be flawed. However, commenter does not say what factors or how such factors should affect the rule.

RESPONSE: The Commission disagrees with the commenter's contention that no inquiry was made to determine the causes of the variances in managed care contracts. It has been suggested to the Commission that variations among contract rates is linked to hospital labor expenses, due to the fact that such expenses make up a major portion of total hospital expenses. Labor costs across regions as set out in the Bureau of Labor Statistics average hourly wage index for Texas metropolitan statistical areas (MSAs) were compared with the average hospital per diem rates contained in contracts for hospitals in the same region. No correlation between higher labor costs and higher per diem rates was observed; i.e. the higher per diem rates were not in the areas with higher labor costs. In fact, in some regions, there was a negative correlation- a region with a low wage index and higher managed care contract rates.

To further evaluate the variances in managed care contract rates, the Commission identified hospitals that are in the same chain, and looked at the contract rates for different hospitals contracting with the same carrier in the same MSA; for the same hospital contracting with the same carrier in different MSA's; and for the same hospital contracting with different carrier in the same MSA. The analysis revealed that there is no consistency among hospitals in the same chain of hospitals which are contracting with the same carrier in the same MSA; there is no consistency among a specific hospital's contracts with the same carrier in different MSA's; and there is no consistency among a specific hospital's contracts with different carrier in the same MSA. While there may be some basis or explanation for the variation in contract rates across the state, geographic location was not a major factor, if any.

Hospital type and hospital bed size were also compared with the hospital per diem rates contained in the contracts. Differences which may be attributable to hospital size together with the size

of the population served have been recognized and accounted for by the exemption of hospitals located in a population center of less than 50,000 persons and which have 100 or less licensed beds from the per diem reimbursement rates in the adopted ACIHFG. Differences in levels of care provided by some hospitals have been recognized and accounted for in the ACIHFG by "carving out", or exempting from the per diem reimbursement rates, ICD-9 codes for trauma, burn and HIV cases Other provisions in the rule, including the addition of approximately 7.0% to the surgical per diem rate, also serve to increase actual reimbursement. The Commission therefore concludes that regional rate variation is not necessary for a rate to be fair and reasonable, or to ensure access to quality health care

Average contract rates were utilized because averaging minimizes the effect of outliers in the data because most rates were closer to the average than to either the higher or lower rates, because the lowest rates may not accurately reflect hospital economic factors for all the hospitals with greater rates and because a reimbursement based on an average rate will be a greater incentive for maintaining access to quality health care than use of the lowest rates.

The repeal is adopted under the Texas Labor Code, §402.061 which requires the Commission to adopt rules necessary for the implementation and enforcement of the Texas Workers' Compensation Act; the Texas Labor Code, §408.021, which entitles injured employees to all health care reasonably required by the nature of the injury as and when needed; the Texas Labor Code, §413.002, which requires that the Commission's Medical Review Division monitor health care providers, insurance carriers and claimants to ensure compliance with Commission rules; the Texas Labor Code, §413.006, which authorizes the Commission to appoint advisory committees in addition to the Medical Advisory Committee as it considers necessary; the Texas Labor Code, §413.007, which sets out information to be maintained by the Commission's Medical Review Division; the Texas Labor Code, §413.011, which provides that the Commission by rule establish medical policies and guidelines; the Texas Labor Code, §413.012, which requires periodic review of the medical policies and fee guidelines; the Texas Labor Code, §413.013, which requires the Commission by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review; the Texas Labor Code, §413.015, which requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Commission ensure compliance with the medical policies and fee guidelines through audit and review; the Texas Labor Code, §413.016, which provides for refund of payments made in violation of the medical policies and fee guidelines; the Texas Labor Code, §413.017, which provides a presumption of reasonableness for medical services fees which are consistent with the medical policies and fee guidelines; the Texas Labor Code, §413.019, which provides for payment of interest on delayed payments, refunds or overpayments; and the Texas Labor Code, §413.031, which provides a procedure for medical dispute resolution.

These statutory provisions clearly authorize and require the Commission to adopt a rule such as §134.401 which includes guidelines for fees paid to hospitals for inpatient medical services provided to injured workers. The statutes also state the standards and objectives the Commission is to consider in establishing fee guidelines. In proposing and adopting this Acute Care Inpatient Hospital Fee Guideline the Commission has considered all the standards and objectives established by the legislature, has not considered irrelevant factors, and has reached a reasonable conclusion after considering the relevant factors. The rule is a reasonable means to legitimate objectives.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on June 25, 1997.

TRD-9708256
Susan Cory
General Counsel
Texas Workers' Compensation Commission
Effective date: August 1, 1997
Proposal publication date: February 11, 1997
For further information, please call: (512) 440–3700

♦ ♦ ♦

28 TAC §134.401

The new rule is adopted under the Texas Labor Code, §402.061 which requires the Commission to adopt rules necessary for the implementation and enforcement of the Texas Workers' Compensation Act; the Texas Labor Code, §408.021, which entitles injured employees to all health care reasonably required by the nature of the injury as and when needed; the Texas Labor Code, §413.002, which requires that the Commission's Medical Review Division monitor health care providers, insurance carriers and claimants to ensure compliance with Commission rules; the Texas Labor Code, §413.006, which authorizes the Commission to appoint advisory committees in addition to the Medical Advisory Committee as it considers necessary; the Texas Labor Code, §413.007, which sets out information to be maintained by the Commission's Medical Review Division; the Texas Labor Code, §413.011, which provides that the Commission by rule establish medical policies and guidelines; the Texas Labor Code, §413.012, which requires periodic review of the medical policies and fee guidelines; the Texas Labor Code, §413.013, which requires the Commission by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review; the Texas Labor Code, §413.015, which requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Commission ensure compliance with the medical policies and fee guidelines through audit and review; the Texas Labor Code, §413.016, which provides for refund of payments made in violation of the medical policies and fee guidelines; the Texas Labor Code, §413.017, which provides a presumption of reasonableness for medical services fees which are consistent with the medical policies and fee guidelines; the Texas Labor Code, §413.019, which provides for payment of interest on delayed payments, refunds or overpayments; and the Texas Labor Code, §413.031, which provides a procedure for medical dispute resolution.

These statutory provisions clearly authorize and require the Commission to adopt a rule such as §134.401 which includes

guidelines for fees paid to hospitals for inpatient medical services provided to injured workers. The statutes also state the standards and objectives the Commission is to consider in establishing fee guidelines. In proposing and adopting this Acute Care Inpatient Hospital Fee Guideline the Commission has considered all the standards and objectives established by the legislature, has not considered irrelevant factors, and has reached a reasonable conclusion after considering the relevant factors. The rule is a reasonable means to legitimate objectives.

§134.401. Acute Care Inpatient Hospital Fee Guideline.

(a) Applicability.

(1) This guideline shall become effective August 1, 1997. The Acute Care Inpatient Hospital Fee Guideline (ACIHFG) is applicable for all reasonable and medically necessary medical and/or surgical inpatient services rendered after the effective date of this rule in an acute care hospital to injured workers under the Texas Workers' Compensation Act. These rules shall not apply to acute care hospitals which are located in a population center of less than 50,000 persons and have 100 or less licensed beds, which shall be reimbursed at a fair and reasonable rate.

(2) Psychiatric and/or rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline on these specific types of admissions. For these type of admissions, insurance carriers shall put one of the appropriate following codes on each bill to indicate the type of services performed:
Type of Service-Code
Rehabilitation - Inpatient-IR
Psychiatric - Inpatient-IP

(3) Services such as outpatient physical therapy, radiological studies, and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services. For these type of admissions, insurance carriers shall put one of the appropriate following codes on each bill to indicate the type of services performed:
Type of ServiceCode
Hospital Surgical - Outpatient-HS
Hospital Other - Outpatient-HO
Ambulatory Surgical - Outpatient-AS
Ambulatory Other - Outpatient-AO

(4) Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements. For these type of admissions, insurance carriers shall put one of the appropriate following codes on each bill to indicate the type of services performed:
Type of Service-Code
Ambulatory Surgical - Outpatient-AS
Ambulatory Other - Outpatient-AO

(5) Emergency services that do not lead to an inpatient admission are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services. Except as listed in subsection (c)(4)(B) of this section, emergency transportation shall be reimbursed in accordance with the Texas Workers' Compensation Commission Medical Fee Guideline in effect at the time the services are rendered.

(b) General Ground Rules.

(1) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(A) Acute Care Hospital - A health care facility that provides inpatient or outpatient services delivered to patients experiencing acute illness or trauma as licensed by the Texas Department of Health (TDH) as a General or Special Hospital Type.

(B) Inpatient Services - Health care, as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital.

(C) Institutional Services - All non-physician services rendered within the hospital by an employee or agent of the hospital.

(D) Length of Stay (LOS) - Number of calendar days from admission to discharge. In computing a patient's length of stay, the day of admission is counted, but the day of discharge is not.

(E) Medical Admission - Any hospital admission where the primary services rendered are medical in nature.

(F) Stop-Loss Payment - An independent method of payment for an unusually costly or lengthy stay.

(G) Stop-Loss Reimbursement Factor (SLRF) - A factor established by the Commission to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.

(H) Stop-Loss Threshold (SLT) - Threshold of total charges established by the Commission, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor by the total charges identifying that particular threshold.

(I) Surgical Admission - Any hospital admission where the primary services rendered are surgical in nature. The surgical nature of the service is indicated by the use of a surgical procedure code.

(J) 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.

(2) General Information.

(A) All hospitals shall bill their usual and customary charges. The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:

(i) a rate for worker's compensation cases pre-negotiated between the carrier and hospital;

(ii) the hospital's usual and customary charges; or
(iii)reimbursement as set out in subsection (c) of this section for that admission.

(B) Additional reimbursements as outlined in subsection (c)(4) of this section are determined on a case-by-case basis within the guidelines established for the specific services rendered.

(C) All charges submitted are subject to audit as described in Commission rules.

(D) All bills for professional services rendered by a health care practitioner shall be submitted on form TWCC-67, the standard HCFA 1500 form.

(E) All bills for acute care hospital inpatient services shall be submitted on form TWCC-68a, the standard UB-92 (HCFA 1450) form. Depending upon the type of service(s) rendered, the appropriate code shall be included on each UB-92 (HCFA 1450) submitted. One of the following codes shall be put on the bill by the insurance carrier:

Type of Service-Code
Acute Care - Inpatient (Medical)-IM
Acute Care - Inpatient (Surgical)-IS

(F) When a medical admission takes place, and surgery is subsequently performed during this stay, the entire stay is considered to be a surgical admission.

(c) Reimbursement.

(1) Standard Per Diem Amount . The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows:

Medical-$ 870
Surgical$ 1,118
Intensive Care Unit (ICU)/Cardiac Care Unit (CCU)- $ 1,560

(2) Method. All 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.

(A) The complete treatment of an injured worker is categorized into two admission types: medical or surgical. A per diem amount shall be determined by the admission category.

(B) A per diem amount is also established for reimbursement of each specific ICU/CCU day independently. This special per diem rate is used for each ICU/CCU day in lieu of the specific (medical/surgical) per diem rate being used for normal services rendered during this admission.

(C) Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection or if the ICD-9 primary diagnosis code is listed in paragraph (5) of this subsection.

(3) Reimbursement Calculation.

(A) Explanation.

(i) Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical).

(ii) The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission.

(iii) If applicable, ICU/CCU days are subtracted from the total LOS and reimbursed the ICU/CCU per diem rate for those specific days of treatment in lieu of the assigned medical/surgical per diem rate.

(iv) The Workers' Compensation Reimbursement Amount (WCRA) is the total amount of reimbursement to be made for that particular admission.

(B) Formula. LOS x SPDA = WCRA.

(C) Examples.

(i) Without ICU/CCU days: admission category - medical; length of stay - eight days; per diem (medical) - $870; eight days at $870 equals $6,960.

(ii) With ICU/CCU days: admission category - surgical; length of stay-15 days; ICU/CCU days-three days; per diem (surgical)-$1,118; per diem (ICU/CCU)$1,560. Fifteen total days minus three ICU/CCU days equals 12 surgical days. Twelve days at $1,118 plus three days at $1,560 equals $18,096.

(4) Additional Reimbursements. All items listed in this paragraph shall be reimbursed in addition to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursements apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

(A) When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%:

(i) Implantables (revenue codes 275, 276, and 278), and

(ii) Orthotics and prosthetics (revenue code 274).

(B) When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate:

(i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619);

(ii) Computerized Axial Tomography (CAT scans) (revenue codes 350-352, 359);

(iii) Hyperbaric oxygen (revenue code 413);

(iv) Blood (revenue codes 380-399); and

(v) Air ambulance (revenue code 545).

(C) Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time.

(5) Reimbursement for Certain ICD-9 Codes. When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate:

(A) Trauma (ICD-9 codes 800.0-959.50);

(B) Burns (ICD-9 codes 940-949.9); and

(C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9).

(6) Stop-Loss Method. Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. This methodology shall be used in place of and not in addition to the per diem based reimbursement system. The diagnosis codes specified in (c)(5) are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.

(A) Explanation.

(i) To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold.

(ii) This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.

(iii) If audited charges exceed the stop-loss threshold, reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%.

(iv) The Stop-Loss Reimbursement Factor is multiplied by the total audited charges to determine the Workers' Compensation Reimbursement Amount (WCRA) for the admission.

(v) Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are personal items (e.g., telephone, television). If an on-site audit is performed, charges for services which are not documented as rendered during the admission may be deducted. Items and services which are not related to the compensable injury may be deducted. The formula to obtain audited charges is as follows: Total Charges - Deducted Charges = Audited Charges

(B) Formula. Audited Charges x SLRF = WCRA

(C) Example.
Total Charges:-$108,000
Deducted Charges:-$8,001
Audited Charges:-$99,999
$99,999 x .75 equals $74,999.25 (WCRA).

(7) Reimbursement for Other Services.

(A) Professional Services. All professional services performed by a health care practitioner shall be reimbursed in accordance with the Texas Workers' Compensation Commission Medical Fee Guideline currently in effect.

(B) Pharmacy Services. Pharmaceutical services rendered as part of inpatient institutional services are included in the basic reimbursement established by subsection (c)(1) of this section. Pharmaceutical services shall not be reimbursed separately except as listed in subsection (c)(4)(C) of this section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on June 25, 1997

TRD-9708257
Susan Cory
General Counsel
Texas Workers' Compensation Commission
Effective date: August 1, 1997
Proposal publication date: February 11, 1997
For further information, please call: (512) 440-3700

♦ ♦ ♦

TITLE 31. NATURAL RESOURCES AND CONSERVATION

Part II. Texas Parks and Wildlife Department

Chapter 65. Wildlife

Subchapter A. Statewide Hunting and Fishing Proclamation

General Provisions

31 TAC §§65.1, 65.3, 65.5, 65.9, 65.11, 65.24, 65.26, 65.27

The Texas Parks and Wildlife Commission adopts the repeal of §§65.11, 65.13, 65.15, 65.21, 65.42, 65.46, 65.58, and 65.64; amendments to §§65.1, 65.3, 65.5, 65.9, 65.24, 65.26, 65.27, 65.44, 65.48, 65.50, 65.52, 65.56, 65.71, 65.72, and 65.78; and new §§65.11, 65.42, 65.46, and 65.64, concerning the Statewide Hunting and Fishing Proclamation. The amendments to §§65.3, 65.5, and 65.72 and new §§65.11, 65.42, and 65.64 are adopted with changes to the proposed text as published in the March 11, 1997, issue of the *Texas Register* (22 TexReg 2965). The repeals and amendments to §§65.1, 65.9, 65.24, 65.26, 65.27, 65.44, 65.48, 65.50, 65.52, 65.56, 65.58, 65.71, and 65.78, and new §65.46 are adopted without changes and will not be republished. The change to §65.3 adjusts the definition of 'coastal waters boundary' to exclude two ponds in Corpus Christi and two ponds in Port Lavaca from status as coastal waters. The change to §65.5 is a nonsubstantive clarification of the section title. The change to §65.11, concerning means and methods, separates the provisions concerning crossbows from those concerning other archery equipment in order to eliminate confusion. The change to §65.42, concerning deer, removes Galveston County from the group of counties having an archery-only white-tail season; eliminates Andrews, Gaines, and Cochran counties from the list of counties having an open season for mule deer; and adds clarifying language to specify that longbow, compound, bow, and recurved bow are the only lawful means during an archery-only season, except as provided in §65.11. The change to §65.64, concerning turkey, removes provisions prohibiting the use of crossbows during the spring seasons for Rio Grande birds and adjusts the fall season in Willacy County to run concurrently with that county's general open deer season. The change to §65.72, concerning fish, eliminates proposed provisions restricting the use of live bait on certain reservoirs.

The repeals, amendments, and new sections are necessary to implement the statutory duty of the department to regulate the commercial and recreational harvest of the wildlife resources of this state. The repeals, amendments, and new sections will function to eliminate duplication and unnecessary regulations, restructure and reorganize regulatory provisions in the interest of promoting user-friendliness, and implement regulatory changes which advance the Commission policy of increasing recreational opportunity within the tenets of sound biological management practices.

The amendment to §65.1, concerning Application, rewords the provisions of subsection (a) to make it clear that the proclama-

10

25 TEXREG 2126, *

1 of 1 DOCUMENT

TEXAS REGISTER

ISSUE: Volume 25, Number 10

ISSUE DATE: March 10, 2000

SUBJECT: ADOPTED RULES

25 TEXREG 2126

TEXAS ADMINISTRATIVE CODE CITATION: 28 TAC § 133.1

TITLE 28 INSURANCE

PART 2 TEXAS WORKERS' COMPENSATION COMMISSION

CHAPTER 133 GENERAL MEDICAL PROVISIONS

SUBCHAPTER A GENERAL RULES FOR REQUIRED REPORTS

Star pagination is in accord with Texas Register hardcopy pagination.
To view the next page, type .np* and TRANSMIT
To view a specific page, transmit p* and the page number. E.G. p*1.

---

§ 133.1. Definitions for Chapter 133, Benefits - Medical Benefits

(a) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Acknowledgment date- The date a document is deemed received under § 102.5(d) of this title (relating to General Rules for Written Communications to and from the Commission)
[*2127]
(2) Commission- The Texas Workers' Compensation Commission.

(3) Complete medical bill - A medical bill that:

(A) is submitted timely, in accordance with § 134.801 of this title (relating to Submitting Medical Bills for Payment);

(B) is on the Commission-prescribed form and that includes the information required by the instructions for the form;

(C) includes correct billing codes from Commission fee guidelines in effect on the date(s) of service (unless the bill is a request for reimbursement by a person other than a health care provider);

(D) contains supporting documentation when such documentation is specifically required by Commission rules or guidelines, unless the required documentation was previously provided to the insurance carrier or its agents; and

(E) includes the following legible supporting documentation, unless previously provided to the insurance carrier or its agents:

(i) for the three highest level office visits, single and interdisciplinary programs such as work conditioning programs, work hardening programs, and physical medicine treatment(s) and/or services(s): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which shall substantiate the care given and the need for further treatment(s) and/or services(s), and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates,

(ii) for surgical services rendered on the same date for which the total of the fees established in the current Commission fee guideline of greater than $500 or DOP (documentation of procedure): a copy of the operative report,

(iii) for a medical bill that includes charges for the professional component of diagnostic, radiological, or pathological tests: a report on the test results, and

(iv) for hospital services: an itemized statement of charges

(4) Date of service - The actual date on which a health care provider provided treatment(s) and/or service(s) to an injured employee

(5) Division - The Medical Review Division of the Texas Workers' Compensation Commission.

(6) Explanation of benefits - The information an insurance carrier sends to the required parties when it makes payment or denies payment on a medical bill, and that includes, when it has reduced or denied payment on the bill, an explanation of all the reason(s) for the reduction and/or denial.

(7) Emergency - Either a medical or mental health emergency as described below:

(A) a medical emergency consists of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part

(B) a mental health emergency is a condition that could reasonably be expected to present danger to self or others

(8) Fair and reasonable reimbursement - 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

(9) Health care provider or provider -

(A) an individual who is licensed to provide or render and who provides or renders health care; or

(B) a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor; or

(C) a hospital, emergency clinic, outpatient clinic, or other facility that provides health care.

(10) Insurance carrier or carrier -

(A) a person authorized and admitted by the Texas Department of Insurance to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance;

(B) a certified self-insurer for workers' compensation insurance; or

(C) or a governmental entity that self-insures, either individually or collectively

(11) Insurance carrier agent - A person or entity that the insurance carrier contracts with or utilizes for the purpose of providing claims service or fulfilling the insurance carrier's obligations under the Texas Labor Code or Commission rules

(12) Payment exception codes - The Commission-mandated codes insurance carriers use to identify the general rationale for reducing or denying payment for a properly completed medical bill.

(13) Reconsideration - The second review an insurance carrier shall perform of a health care provider's medical bill or preauthorization request, in response to the health care provider's request for the second review

(14) Required medical report - A medical report, and/or narrative report that a health care provider submits in accordance with this title

(15) Retrospective review - The process of an insurance carrier reviewing health care that has been provided to an injured employee in order to determine if the health care rendered was reasonable and medically necessary and billed in accordance with the appropriate Commission fee guideline, as described in § 133.301 of this title (relating to Retrospective Review of Medical Bills). The insurance carrier may perform this process manually or through automation.

(16) Unbundling - Submitting bills in a fragmented way, using separate billing codes for multiple treatments or services when there is a single billing code that includes all of the treatments or services that were billed separately, or fragmenting one treatment or service into its component parts and coding each component part as if it were a separate treatment or service
[*2128]
(17) Upcoding - Using a diagnosis or billing code that does not best represent the injured employee's actual condition or the treatment or service actually performed.

(b) This rule shall apply to all dates of service on or after July 15, 2000.

HISTORY:

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 22, 2000

TRD-200001312

Susan Cory

General Counsel

Texas Workers' Compensation Commission

Effective date: July 15, 2000

Proposal publication date: November 19, 1999

For further information, please call: (512) 804-4287

NOTES:

The new rule is adopted under the following statutes: Texas Labor Code, § 402.061, which gives the Commission the authority to adopt rules as necessary to implement and enforce the Act; Texas Labor Code, § 401.023, which directs the Commission to set an interest or discount rate; Texas Labor Code, § 401.024 as amended by the 76th Texas Legislature,

which provides the Commission the authority to require use of facsimile or other electronic means to transmit information in the system; Texas Labor Code, § 402.042, which authorizes the executive director to enter orders as authorized by the statute as well as to prescribe the form manner and procedure for transmission of information to the Commission; Texas Labor Code, § 406 010, which authorizes the Commission to adopt rules regarding claims service; Texas Labor Code, § 408.025, which requires the Commission to specify by rule the reports a health care provider is required to file; Texas Labor Code, § 408 027, which provides for insurance carrier payment of health care providers; Texas Labor Code § 409.009, which allows a person to become a sub-claimant to a workers' compensation claim; Texas Labor Code, § 413 007, which directs the Medical Review Division to maintain a statewide database of medical billing information; Texas Labor Code, § 413 015, which directs insurance carrier payments to and audits of health care providers; Texas Labor Code, § 413 019, which directs that interest be paid on late payments, refunds, or overpayments; Texas Labor Code, § 413.031, which directs medical dispute resolution; Texas Labor Code § 413.042, which prohibits private claims

ADOPTED RULES: An agency may take final action on a section 30 days after a proposal has been published in the Texas Register The section becomes effective 20 days after the agency files the correct document with the Texas Register, unless a later date is specified or unless a federal statute or regulation requires implementation of the action on shorter notice

If an agency adopts the section without any changes to the proposed text, only the preamble of the notice and statement of legal authority will be published If an agency adopts the section with changes to the proposed text, the proposal will be republished with the changes