No. 09-0162

IN THE SUPREME COURT OF TEXAS

VISTA COMMUNITY MEDICAL CENTER, LLP, *et al.*,
Petitioners,
v.

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

On Petition for Review
From the Third Court of Appeals at Austin

BRIEF OF AMICUS CURIAE

INSURANCE COUNCIL OF TEXAS

Respectfully submitted,

John D. Pringle
State Bar No. 16330300
JOHN D. PRINGLE, P.C.
The Vaughn Building
807 Brazos, Suite 200
Austin, Texas 78701
(512) 472-8742
(512) 472-8745 (Facsimile)

ATTORNEY FOR INSURANCE COUNCIL OF TEXAS

December 9, 2009

No. 09-0162

IN THE SUPREME COURT OF TEXAS

VISTA COMMUNITY MEDICAL CENTER, LLP, *et al.*,
Petitioners,
v.

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

On Petition for Review
From the Third Court of Appeals at Austin

BRIEF OF AMICUS CURIAE

INSURANCE COUNCIL OF TEXAS

Respectfully submitted,

John D. Pringle
State Bar No. 16330300
JOHN D. PRINGLE, P.C.
The Vaughn Building
807 Brazos, Suite 200
Austin, Texas 78701
(512) 472-8742
(512) 472-8745 (Facsimile)

ATTORNEY FOR INSURANCE COUNCIL OF TEXAS

December 9, 2009

TABLE OF CONTENTS

Page

TABLE OF CONTENTS ii

INDEX OF AUTHORITIES iv

STATEMENT OF THE CASE ix

ISSUES PRESENTED x

STATEMENT OF FACTS 1

SUMMARY OF THE ARGUMENT 20

ARGUMENT 21

I. Is the "stop-loss" exception in the 1997 Fee Guideline invalid if it fails to provide effective medical cost control? Does the "stop-loss"exception require a two-prong test be met before the "stop-loss" exception reimbursement methodology is applied? 21

II. Does the example in "stop-loss" exception of the 1997 Fee Guideline support the contentions of Petitioners? Are the claims of Petitioners, *Amici* THA, and Respondent Division regarding a single bright-line reimbursement supported by the Act, rules and record? 27

III. Does the Act or agency's rules prevent a hospital from determining its own charges for services and items provided prior to March 1, 2008? Do the agency's audit rules allow insurance carriers to reduce a hospital's charge to a fair and reasonable amount? 33

A. Usual and Customary 33

B. Carrier Audit Rights 35

C. SOAH's Treatment of Carrier Audits 40

D. Commission's Treatment of Carrier Audits 41

CONCLUSION AND PRAYER 42

CERTIFICATE OF SERVICE 44

APPENDIX 47

INDEX OF AUTHORITIES

CASES PAGES

AT&T Communications of Tex. L.P. v. Southwestern Bell Tel. Co.,
No. 03-0789, 2006 Tex. LEXIS 93, at *33-34 (Tex. Jan. 27, 2006) 42

Board of Insurance Commissioners v. Guardian Life Insurance Company,
180 S.W. 2d 906 (Tex. 1944) 24

Crown Life Ins. Co. v. Casteel, 22 S.W.3d 378, 383 (Tex. 2000) 22

Gerst v. Oak Cliff Sav. & Loan Ass'n, 432 S. W.2d 702, 706 (Tex. 1968) 23

Gulf Coast Water Co. v. Cartwright,
160 S.W.2d 269 (Tex. Civ. App. - Galveston 1942, writ ref'd w.o.m.) 25

Hawkins v. Dallas County Hosp. Dist.,
150 S.W.3d 535 (Tex. App.- Austin 2004, no pet.) 37

Havner v. Meno, 867 S.W. 2d 130, 134
(Tex. App. - Austin 1993, no writ) 24

Hidi v. State and County Mutual Fire Ins. Co.,
988 S.W.2d (Tex.App.- Austin 1999),
rev'd on other grounds 13 S.W.3d 767 (Tex. 2000) 22

Key Western Life Insurance Company v. State Board of Insurance,
350 S.W. 2d 839 (Tex. 1961) 24

Mid-Century Insurance Company v. Texas Workers' Compensation Commission,
187 S.W.3d 754, 758 (Tex. App. – Austin 2006, no pet.) 42

Mitchell Energy Corp. v. Ashworth, 943 S.W.2d 436, 438 (Tex. 1997) 22

Moseley v. Behringer,
184 S.W.3d 829 (Tex. App. - Fort Worth 2006, no pet.) 37

Pruett v. Harris County Bail Bond Bd., 249 S.W.3d 447, 452 (Tex. 2008) 23

Public Util. Comm'n v. Gulf States Utils. Co.,
809 S.W.2d 201, 207 (Tex. 1991) 29

Railroad Comm'n v. Lone Star Gas Co., 844 S.W. 2d 679, 685 (Tex. 1992) 24

Sexton v. Mount Olivet Cemetery Ass'n,
720 S.W. 2d 129 (Tex. App. - Austin 1986, writ ref'd n.r.e.) 24

Southwestern Life Ins. Co. v. Montemayor, 24 S.W.3d 581, 585
(Tex. App. - Austin 2000, pet. denied) 42

State v. Public Util. Comm'n of Tex.,
131 S.W.3d 314 (Tex. App.- Austin 2004, pet. denied) 39

Tex. Antiquities Comm. v. Dallas County. Community College Dist.,
554 S.W. 2d 924, 927-928 (Tex. 1977) 24

Texas Gen. Indem. Co. v. Eisler, 981 S.W.2d 744, 747 n.2
(Tex. App.-Houston [1st Dist.] 1998, no pet.) 42

Texas Hosp. Ass'n v. Texas Workers' Comp. Comm'n,
911 S.W.2d 884, 886 (Tex. App. – Austin 1995, writ denied) 1

Tex. Mut. Ins. Co. v. Vista Cmty. Med. Ctr., LLP,
275 S.W.3d 538, 550 (Tex. App. - Austin 2008, pet. filed) 25, 29, 42

Tex. Workers' Comp. Comm'n v. Patient Advocates,
136 S.W.3d 643 (Tex. 2004) 38

STATUTES

TEX. GOV'T CODE § 311.016(2) 37

TEX. GOV'T CODE § 311.021 22

TEX. GOV'T CODE § 311.023 22

TEX. GOV'T CODE § 311.023(6) 29

TEX. GOV'T CODE § 312.005 22

TEX. LAB. CODE § 408.027(e) 32

TEX. LAB. CODE § 409.0091(h) 39

TEX. LAB. CODE § 413.011 . . . . 19, 21, 22

TEX. LAB. CODE § 413.011(b) 2, 23

TEX. LAB. CODE § 413.011(d) 2, 18, 23, 39

TEX. LAB. CODE § 413.031(d) 32

TEX. LAB. CODE § 413.031(k) 32

TEX. LAB. CODE § 415.005 33

Act of June 17, 2001, 77th Leg., R.S., ch. 1456, § 6.02, 2001 Tex. Gen.
Laws 1456 23

Act of May 29. 2005, 79th Leg. R.S., ch. 265, §§ 8.001(b), 8.004(a),
2005 Tex. Gen. Laws 468, 607-11 1

AGENCY RULES

28 TEX. ADMIN. CODE § 133.2(1) 4

28 TEX. ADMIN. CODE § 133.20(e)(1) 34

28 TEX. ADMIN. CODE § 133.230 36

28 TEX. ADMIN. CODE § 133.301(a) (repealed effective May 2, 2006) 36, 37, 39

28 TEX. ADMIN. CODE § 133.304 . . . . 37, 38

28 TEX. ADMIN. CODE §133.304(i) 38, 39

28 TEX. ADMIN. CODE §134.1 20

28 TEX. ADMIN. CODE § 134.401(b)(2)(A) 34

28 TEX. ADMIN. CODE § 134.401(b)(2)(C) 36

28 TEX. ADMIN. CODE § 134.401(c)(6)(A)(v) 35, 36

28 TEX. ADMIN. CODE § 134.404 33

28 TEX. ADMIN. CODE § 134.404(a)(2) 19

OTHER AUTHORITIES

22 Tex. Reg. 6264-6303 (July 4, 1997) . . . . *passim*

25 Tex. Reg. 2128 (March 10, 2000) 36, 38, 39

31 Tex. Reg. 1539 (March 10, 2000) 36

31 Tex. Reg. 3544 (April 28, 2006) 35, 38, 39

33 Tex. Reg. 1487 (February 22, 2008) 19

SOAH Docket No. 453-05-9025.M5; *Ace Insurance Company of Texas v. Vista Medical Center Hospital* (T. Broyles presiding) 41

SOAH Docket No. 453-05-7487.M4; *Ace Insurance Company of Texas v. Vista Medical Center Hospital* (T. Broyles presiding) 41

SOAH Docket No. 453-04-4223.M4; *American Home Assurance Co. v. Baylor Univ. Med. Ctr*. (H. Card presiding) 35

SOAH Docket No. 453-00-2092.M4; *City of Fort Worth v. All Saints Hospital System and Texas Workers' Compensation Commission* (G. Cunningham presiding) 5, 6

SOAH Docket No. 453-04-3600.M4; *Dillards' Dep't. Stores v. Huguley Memorial Hosp*. (C. Church presiding) 35

SOAH Docket No. 453-01-1612.M4; *Facility Insurance Corporation v. Rio Grande Regional Hospital and Texas Workers' Compensation Commission* (G. Cunningham presiding) 6

SOAH Docket No. 453-05-2804.M5; *Pacific Employers Insurance Company v. Vista Medical Center Hospital* (J. Norman presiding) 41

SOAH Docket No. 453-05-9670.M4; *Rio Grande Regional Hospital v. Texas Mutual Insurance Company* (H. Seitzman & T, Broyles presiding) 40

SOAH Docket No. 452-03-1233.M4; *San Antonio I.S.D. v. Metropolitan Meth. Hosp.*, (T. Walston presiding) 35

SOAH Docket No. 453-05-9178.M4; *Vista Medical Center Hospital v. Pacific Employers Insurance Company* (J. Norman presiding) 41

SOAH Docket No. 453-05-5471.M4; *Vista Medical Center Hospital v. Pacific Employers Insurance Company* (J. Norman presiding) 41

SOAH Docket No. 453-03-2412.M4; *Vista Medical Center Hospital v. Texas Mutual Insurance Company* (S. Ramos presiding) 14

SOAH Docket No. 453-03-0910.M4, *Zurich American Insurance Company v. Texas Workers' Compensation Commission and HealthSouth Medical Center* (K. Sullivan presiding) 6

STATEMENT OF THE CASE

Nature of the case:	This is an appeal of a declaratory judgment action. Two hospitals and a group of carriers sought competing declaratory judgments on the interpretation and validity of an agency rule setting the fees that must be paid to hospitals for workers' compensation patients.
Trial court:	Hon. Margaret A. Cooper, sitting in the 353rd District Court, Travis County
Trial court disposition:	The trial court held that the rule requires hospitals to be paid 75% of hospital-set charges, instead of the standard per diem, whenever the total hospital charges exceeded $40,000, and that this rule was valid.
Court of Appeals parties:	Vista Community Medical Center, L.P. and Christus Health Gulf Coast (collectively, Vista), Texas Mutual Insurance Company, Liberty Mutual Insurance Company, Zenith Insurance Company, and Zurich American Insurance Company (collectively, carriers), and the Texas Department of Insurance, Division of Workers' Compensation
Court of Appeals:	Third Court of Appeals at Austin, Texas; Justice Patterson, joined by Justices Waldrop and Henson; *Tex. Mut. Ins. Co. v. Vista Cmty. Med. Ctr., LLP*, 275 S.W.3d 538 (Tex. App. – Austin 2008, pet. filed).
Court of Appeals disposition:	The Court of Appeals reversed the trial court's judgment and held that the rule requires hospitals to be paid the standard per diem amount unless the hospital demonstrates that an admission involves more than $40,000 in charges *and* unusually costly and unusually extensive services. The court of Appeals did not reach the question of whether a rule that required payment of 75% of hospital charges whenever they exceed $40,000 would be invalid.

ISSUES PRESENTED

Insurance Council of Texas agrees with and adopts the Issues Presented in Carriers' Brief on the Merits and Zurich American Insurance Company's Brief on the Merits, including the attendant arguments set forth on each issue, and would add the following:

1. Is the stop-loss exception in the 1997 Fee Guideline invalid if it fails to provide effective medical cost control? Does the stop-loss exception require a two-prong test be met before the stop-loss exception reimbursement methodology is applied?

Did the court of appeals err in holding that the stop-loss exception to the 1997 Fee Guideline requires a hospital must demonstrate that total audited charges exceed $ 40,000 and that the admission involves unusually costly services to obtain reimbursement?

2. Does the example in stop-loss exception of the 1997 Fee Guideline support the contentions of Petitioners? Are the claims of Petitioners, *Amici Curiae* Texas Hospital Association, *et al.*, and Respondent Texas Department of Insurance, Division of Workers' Compensation regarding a single bright-line reimbursement being valid supported by the Act, rules and record?

In interpreting an agency rule should a court give greater weight to some words over others? Does a mathematical calculation following the requirements for application of an exception to the standard per diem method of reimbursement mean that some of the words of a rule should be ignored?

3. Does the Act or agency's rules prevent a hospital from determining its own charges for services and items provided prior to March 1, 2008? Do the agency's audit rules allow insurance carriers to reduce a hospital's charge to a fair and reasonable amount?

Do the statutory and administrative language requiring fair and reasonable reimbursement to a hospital by an insurance carrier authorize an insurance carrier to reduce a hospital's charges to a lesser amount when making payment?

STATEMENT OF FACTS

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

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

In August 1997, after the Texas Workers' Compensation Commission's 1992 Hospital Fee Guideline was invalidated on procedural grounds in *Texas Hosp. Ass'n v. Texas Workers' Comp. Comm'n*, 911 S.W.2d 884, 886 (Tex. App. – Austin 1995, writ denied), the Texas Workers' Compensation Commission (Commission)[1] adopted an Acute Care Inpatient Hospital Fee Guideline (the 1997 Guideline) by rule relating to payments

1. In 2005, the Texas Legislature abolished the Texas Workers' Compensation Commission and transferred its duties and rules to the Texas Department of Insurance, Division of Workers' Compensation. See Act of May 29. 2005, 79th Leg. R.S., ch. 265, §§ 8.001(b), 8.004(a), 2005 Tex. Gen. Laws 468, 607-11. ICT will try and refer to the Texas Workers' Compensation Commission ("Commission"), in this Statement of Facts when any action was taken by the Commission and will try and refer to the Texas Department of Insurance, Division of Workers' Compensation ("Division"), in this Statement of Facts when any action was taken by the Division.

to hospitals for services provided to workers' compensation patients. 22 Tex. Reg. 6264 (July 4, 1997), Joint Exhibit 1-2. In the 1997 Guideline, the Commission adopted the same per diem methodology for payments to hospitals as in the 1992 Hospital Fee Guideline, with slightly different payment amounts. For example, the surgical per diem was increased by seven (7%) percent. 22 Tex. Reg. 6268. The medical per diem was increased by approximately forty-five (45%) percent. 22 Tex. Reg. 6266. In the order adopting the 1997 Guideline, the Commission clearly described the reasons that statewide per diems based on three large groups met Texas Labor Code Section 413.011(b) criteria.[2]

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

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

2. Now § 413.011(d).

> inflation rate of 29% and 18% respectively. *For these reasons, hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors.*

22 Tex. Reg. 6297. (Emphasis added).

In rejecting a percentage of (or discount from) billed charges method of reimbursement, the Commission noted such a method "leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control. 22 Tex. Reg. 6276. Adopting Petitioners' and *Amici* Texas Hospital Association, *et al.* (*Amici* THA), "bright-line"over $40,000 test results in automatic payment does the same thing.

I. The Dispute Over the "Stop-Loss" Exception

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

A. Early Commission Staff Communications

In October 1997, Commission staffer Nancy Crawley instructed attendees at the Texas Medical Cost Containment Association conference that implants should be reduced to cost plus ten (10%) percent when reviewing a hospital bill to determine if the bill met the minimum "stop-loss" threshold. Joint Exhibit 1-3-1 at p. 8. In October 1999, Vangie Stice, Section Chief for the Commission's Medical Review Division ("MRD"), responded to an inquiry regarding whether the $40,000 minimum "stop-loss" threshold is met based on the the invoice price of the implants (cost to the hospital) or the charged price of the implants (to the insurance carrier). Ms. Stice stated: "According to the Acute Care Inpatient Hospital Fee Guideline, (c)(4)(A), the maximum allowable reimbursement (MAR) for implantables is cost plus ten (10%) percent. That means that the carrier would reimburse the hospital $9,900 for an implantable for which the hospital paid $9,000. The carrier would use the MAR to determine whether the total bill reached the stop-loss threshold." Joint Exhibit 8-9. Then, in February 2000, Dee Torres, an Information Specialist at the MRD, responded to a similar inquiry stating: "Audited charges are what's left after appropriate reductions (such as costs + 10% for implants)." *Id.* For more than three (3) years the Commission staff maintained this interpretation as agency policy.

B. The Implant QRL

However, in October 2000, a different answer regarding implants was published in the format of a Question Resolution Log ("QRL"). A QRL is a tool intended for Commission employees to respond to common questions in medical fee disputes. A QRL

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

<u>C. The Initial "Stop-Loss" Exception Decisions by SOAH</u>

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

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

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

In July 2001, in SOAH Docket No. 453-01-1612.M4; *Facility Insurance Corporation v. Rio Grande Regional Hospital and Texas Workers' Compensation Commission*, the second SOAH decision to interpret the “stop-loss” exception, Ms. Shank again testified that the Commission policymakers' original intent regarding the “stop-loss” exception was to "ensure hospitals were fairly reimbursed for unusually complex cases or unusually long admissions." Joint Exhibit 1-3-2, at p. 3. For an admission in April 2000, Ms. Shank testified that "the present case was not uncommon, the services rendered were not unusually costly or extensive, and the admission was for only four days."[3] *Id.*

After ALJ Cunningham's 2001 Decisions raised the issue of unusually extensive services, a number of other SOAH ALJ decisions issued in 2003 and 2004 concluded that

---

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

the “stop-loss” exception did not apply unless the hospital demonstrated that the services provided were unusually costly or unusually extensive.[4]

II. The Two-Prong Test

The 1992 Hospital Fee Guideline, which the Austin Court of Appeals invalidated, also contained a “stop-loss” exception. Joint Exhibit 13 at p. 6. Lisa Hannusch, the Respondent Division's expert witness at trial in this case (Joint Exhibit 13 at p. 125), worked at the Commission between 1990 and 1996 and served on the rulemaking committee for the 1992 Hospital Fee Guideline and the 1997 Guideline. Joint Exhibit 13 at p. 6-7. Ms. Hannush’s report confirmed the Commission’s intent that the “stop-loss” exception was provided for truly unusual admissions as an exception to the standard admission. Joint Exhibit 13-1 p.3.

Ms. Hannusch's report confirmed that the Commission's intent regarding the “stop-loss” exception has always been the same: "The stop-loss methodology was provided for truly unusual admissions as an exception to standard admissions." Joint Exhibit 13-1, page 3; Joint Exhibit 13 at p. 24. According to Ms. Hannusch, application of the “stop-loss” exception required first that the admission be classified as unusually extensive and

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

costly before the mathematical calculation of seventy-five (75%) percent could be applied to total audited charges. Joint Exhibit 13 at p. 22. Ms. Hannusch's position has never changed. In December 2004, Ms. Hannusch testified at SOAH that the "stop-loss" exception required a two prong test, consistent with her testimony in this case. Joint Exhibit 13 at pp. 11–12 and 26-27.

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

Dr. Nicholas Tsourmas, Texas Mutual's Medical Director (RR 2-60), explained Texas Mutual's application of the two prong test in more detail. RR 2-73, 77. He reviews a hospital's medical records of an admission (RR 2-84), to determine whether unusually costly or unusually extensive services were provided. RR 2-86. Dr. Tsourmas has made at least 900 such reviews. RR 2-85.

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

not unusually extensive and costly. RR 2-109, 10.

At the same time as insurance carriers were applying the two-prong test, Vista Medical Center Hospital sought and obtained a statement regarding implant charges from a low-level Texas Workers' Compensation Commission employee. In August 2002, Raegan B. Brown, a Medical Review Division "Information Specialist II," responded to a letter from Vista Medical Center Hospital's lawyer Christina Gutel, who had requested clarification on how implant charges are to be treated under the "stop-loss" exception. Joint Exhibit 9-4. Ms. Brown's letter stated that carriers should audit bills on a line-by-line basis and reduce charges to "usual and customary." Joint Exhibit 9-4 at p. 1. Ms. Brown defined "usual and customary" charge as "the provider's *usual* charge within the *customary* range of fees charged by others in the geographic locality that are *reasonable* based on the medical circumstances." (emphasis in original). Joint Exhibit 9-4 at p. 2. The letter concluded that the 1997 Guideline does not allow implants to be carved out and reimbursed at cost plus ten (10%) percent unless it is first determined that the per diem method applies. Joint Exhibit 9-4 at p. 2-3.

A. Early Medical Review Division Actions on Unusually Extensive

Despite Ms. Brown's letter to Vista Medical Center Hospital, some Medical Dispute Resolution Officers (MDROs) had understood the Texas Workers' Compensation Commissioners' intent that application of the "stop-loss" exception required unusually extensive services. In November 2002, MDRO Carolyn Ollar sent an e-mail to David Martinez, Medical Dispute Resolution (MDR) Section Manager, regarding a proposed

advisory discussing the "stop-loss" exception. Ms. Ollar's email shows the importance of a two prong test: "The other thing we might consider is whether or not these surgeries actually qualify for 'unusually costly services' though I am not sure what criteria we would use. Maybe a review of the explanation of any unusual circumstances resulting in the increased charges and supporting documentation. Back surgeries are done every day and most do not exceed the $40,000 threshold. It would appear that this was meant for treatment such as burns, catastrophic injuries, etc. and that some providers have taken it as a free license to grossly inflate their implants to make a windfall profit." Joint Exhibit 8-19.

The two prong test explicitly appeared in at least one Medical Review Division decision. In December 2002, in MDR Tracking No. M4-02-4447-01, the MDRO stated: "Two of the criteria that must be met to establish entitlement to stop-loss reimbursement are: 1. audited charges in excess of $40,000.00, and 2. the services provided should be unusually extensive/costly. While the provider did bill in excess of $40,000.00, the documentation does not indicate any services that are unusually extensive or costly. The carrier was correct in basing its reimbursement on the per diem methodology in #1 above. Therefore, no additional reimbursement is recommended." Joint Exhibit 1-1 (97-05 00034); Joint Exhibit 8-19.

B. Vista

Vista Medical Center Hospital ("Vista") is a 37 bed specialty hospital in Pasadena, Texas which accounts for the majority of the alleged "stop-loss" exception disputes with

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

Vista's business model is built on "increased amounts of reimbursement for the same or similar procedure, as compared to other health care providers," by avoiding payors that "limit reimbursement." TMIC Exhibit 2 at p. 31. In 2006, in eighty-six (86%) percent of its workers' compensation cases, Vista charged more than $40,000. TMIC Exhibit 1 at p. 13. Vista acknowledged this business model as early as 2003. Phillip Chan, the CEO of Dynacq Healthcare, Inc., the parent company of Vista stated: "`Every patient walking into this hospital is going to have a procedure, and the procedure is going to be expensive.' He went on to explain: 'Our average bill going out to insurance companies is around $50,000. That's what accounts for the revenue per bed.'" Joint Exhibit 5-15.

Vista's billed charges are the result of hefty markups over cost for implants, for services and for supplies. Vista's standard markup schedule for implants is four hundred (400%) percent. Joint Exhibit 6 at p. 67. The record contains one Vista "stop-loss" exception claim against Texas Mutual from 2001, in which an implant invoice to Vista for $10,274.00 became an implant charge by Vista for $41,096.00. TMIC Exhibit 3. Under Vista's interpretation of the "stop-loss" exception, and the holding of Travis County District Judge Margaret Cooper, this one line item charge for implants made it entitled to seventy-five (75%) percent of its charges for the entire admission, which in this case exceeded $200,000.00. For services, Vista's *hourly* charges for preop (more than $1,000.00), operating room (more than $2000.00), anesthesia (nearly $2,000.00) and recovery room ($2,990.00) far exceed the 1997 Guideline's *daily* surgery admission fee of $1,118.00. TMIC Exhibit 1 at p. 4. On an actual 3-day admission the 1997 Guideline's total fair and reasonable payment would be $3,354.00, compared with Vista's time-based charges for just preop, operating room, anesthesia and postop, totaling nearly $40,000. TMIC Exhibit 1 at p. 5. Vista's markups for supplies are between 500% (Joint Exhibit 6 at p. 69) to 40,833.00%. TMIC Exhibit 16.

<u>C. The Vista Consolidated Docket Before ALJ Ramos</u>

In the spring and summer of 2003, the Commission was issuing more and more adverse MRD decisions against Vista Medical Center Hospital. Vista appealed these cases to SOAH where at least one of those cases was assigned to be tried by ALJ Sarah

Ramos. Joint Exhibit 2-3 at p. 1. In July 2003, Texas Mutual, along with Hartford Insurance Company, and Healthcare Corporation\Health South Corporation\ESIS moved to consolidate SOAH cases between the carriers and Vista to obtain a final ruling on application of the 1997 Fee Guideline and its "stop-loss" exception. *Id.*[5] ALJ Ramos consolidated the cases and approved a list of threshold legal issues, including whether the hospital must show an admission is unusually extensive and costly before triggering "stop-loss" exception reimbursement. *Id.* at p. 4-17. To provide context for and understand the consequences of the parties' competing interpretations, ALJ Ramos allowed the parties to conduct extensive fact and expert discovery relevant to the threshold legal issues. Joint Exhibit 5-2; Joint Exhibit 5-4 to Joint Exhibit 5-6; and Joint Exhibit 5-17 to Joint Exhibit 5-23; RR 2-130.

The carriers and Vista briefed the threshold legal issues with reference to the evidence gathered from Vista's witnesses and Carriers' witnesses. Joint Exhibit 2-3 at p. 2. At the same time that the carriers and Vista were litigating threshold legal issues before ALJ Ramos, SOAH ALJ Howard Seitzman decided to consolidate all other "stop-loss" exception medical fee disputes referred from the MRD between all carriers and all Texas hospitals. ALJ Seitzman also abated all of the consolidated cases. Appendix 1. Between December 2004 and January 2006, ALJ Seitzman collected more than 885 "stop-loss" exception cases into the "Stop-Loss Docket." Joint Exhibit 2-1 at p. 8 (page 5 of the

---

5. In Petitioners' Consolidated Reply Brief, footnote 1, Petitioners ignore the fact that 497 of the cases pending at SOAH were Vista's.

Order). These cases would later be subject to the rulings of the *En Banc* Panel, discussed below.

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

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

In SOAH Docket No. 453-03-2412.M4; *Vista Medical Center Hospital v. Texas Mutual Insurance Company* (which was issued after the *En Banc* Panel's rulings, discussed below), ALJ Ramos applied her threshold legal issue rulings to conclude that Vista was not entitled to "stop-loss" reimbursement for an admission which had originally

occurred in 2001, because the admission was not unusually extensive and costly. Joint Exhibit 1-3-18 at p. 10. In the decision, ALJ Ramos noted that Vista's charges exceeded $40,000.00 only because it had inflated its charges for typical hospital services. Joint Exhibit 1-3-18 at p. 10.

ALJ Ramos applied her threshold legal issue rulings to the remaining 7 cases between Texas Mutual and Vista, in each case finding that Vista was not entitled to payment under the "stop-loss" exception because the admission was not unusually extensive and costly.

D. TWCC Confusion

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

TWCC policymakers became even more aware of the confusion within the agency

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

E. "Stop-Loss" Docket Before the En Banc Panel

In January 2006, ALJ Howard Seitzman announced that the "Stop-Loss" Docket, containing approximately 885 other alleged "stop-loss" exception cases, had been assigned for adjudication of threshold legal issues to an *En Banc* Panel of 9 SOAH ALJs. Joint Exhibit 2-1 at p. 8 (page 5 of the Order). As it had in the cases consolidated before ALJ Ramos, Texas Mutual and other carriers tendered the evidence of Dr. Luke and Dr. Tsourmas, to show the Panel the consequences of the parties' competing interpretations. *The Panel, however, refused to consider such evidence.* Appendix 2, Consolidated Order No. 4 Memorializing Prehearing Conference and Issuing Briefing Outline. In November 2006, after extensive briefing by the Hospitals, Texas Mutual, and this time, the Texas Department of Insurance, Division of Workers' Compensation (Respondent Division), the Panel heard oral argument on the threshold legal issues. Joint Exhibit 2-1 at p. 9 (page 6 of the Order). In the briefing and at argument, the Carriers and Respondent Division argued why application of the "stop-loss" exception required a two prong or trigger test

of (1) total audited charges in excess of $40,000 and (2) unusually costly or unusually extensive hospital admission. Joint Exhibit 2-1 at p. 20-21 (pages 17 and 18 of the Order).

In January 2007, the *En Banc* Panel issued its decision on threshold legal issues. The Panel concluded that application of the "stop-loss" exception only requires that the hospital's bill exceed $40,000 in total audited charges. Joint Exhibit 2-1 at p.18 (page 15 of the Order). The Panel found that hospitals are not required to show that an admission is "unusually extensive and costly,"(Joint Exhibit 2-1 at p.18 (page 15 of the Order)), and that the Staff Report is inconsistent with prior MRD decisions and the Division of Workers Compensation's rules and preambles. Joint Exhibit 2-1 at p. 25 (page 22 of the Order). In a subsequent letter clarification of the ruling, the Panel stated that the phrase "the hospital's usual and customary charges" means the hospital's own usual and customary charges, and not to charges that are a median or average of charges in a geographic area. Joint Exhibit 2-2.

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

to the Travis County District Court by numerous carriers. *E.g.*, Joint Exhibit 3-1 to 3-6.

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

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

Texas Mutual filed an answer and a counterclaim to Vista's declaratory judgment lawsuit seeking in part a declaration that the 1997 Guideline, properly interpreted requires a hospital to demonstrate that the services provided in that admission were unusually costly and unusually extensive before the hospital is entitled to "stop-loss" exception reimbursement. Alternatively, Texas Mutual sought a declaration that the "stop-loss" exception is invalid because: (1) it violates Labor Code Section 413.011(d) because it is not designed to achieve effective medical cost control; and (2) it is an unconstitutional delegation of the Commission's power to set medical fees to private parties. CR 17: 996. Zenith intervened in this suit. RR-1-6. The declaratory judgment lawsuit was heard by Judge Margaret Cooper who entered a Final Judgment on November 6, 2007.

G. Post Final Judgment Division Actions

On December 28, 2007, the Division finally adopted a new Hospital Fee Guideline to replace the 1997 Guideline. As required by Labor Code § 413.011, the new Hospital Fee Guideline is based on Medicare reimbursement methodologies. Under the new Hospital Fee Guideline, inpatient admissions are paid at one hundred forty-three (143%) percent of Medicare with implants included, or one hundred eight (108%) percent of Medicare with implants carved out at cost plus ten (10%) percent not to exceed $1,000 per item and $2,000 per admission. The new Hospital Fee Guideline applies to all services provided to workers' compensation patients in an inpatient hospital on or after March 1, 2008. According to the new Hospital Fee Guideline, the 1997 Guideline, and its "stop-loss" exception, continues to apply to services provided before March 1, 2008. 28 TEX. ADMIN. CODE § 134.404(a)(2).

However, in February 2008, Respondent Division proposed the repeal of the 1997 Guideline, saying it was "no longer necessary" for making reimbursement determinations. 33 Tex. Reg. 1487 (February 22, 2008). Texas Mutual and ICT filed comments supporting the repeal, but asked the Respondent Division to make it more explicit in the repeal language that the repeal of the 1997 Guideline applies to all pending "stop-loss" exception cases, whether at the Respondent Division, SOAH, Travis County District Court or on appeal in the appellate courts. Appendix 3, Comments of Texas Mutual and ICT. Instead of adjudicating the pending cases under the repealed 1997 Guideline, Texas Mutual and ICT, among others, argued that reimbursement decisions for pending cases

will be made under the Respondent Division's default rule, 28 TEX. ADMIN. CODE §134.1; Appendix 4, Comments of John D. Pringle.

SUMMARY OF ARGUMENT

The Texas Workers' Compensation Commission was required to design fee guidelines that provided fair and reasonable reimbursements by insurance carriers. The Preamble to the 1997 Fee Guideline stated the Commission rejected a payment method based on a percentage of billed charges because paying a percentage of billed charges failed to provide effective medical cost control. This is because a hospital has no constraints on what it can charge for the services and items provided during an admission.

Although the Texas Workers' Compensation Act and agency rules require that insurance carriers retrospectively review all complete medical bills line by line and pay for or deny payment in accordance with the Act, agency rules, the Commission, some SOAH Administrative Law Judges and the Travis County District Court have denied the insurance carriers' audit powers to reduce the amount of a charge to a lesser amount. Disallowing a reduction of the amount charged for a service or item prevents an insurance carrier from making a fair and reasonable reimbursement to a hospital.

Since a hospital can set any amount it chooses to charge for an item or service, a hospital can set its own reimbursement amount by increasing the amount it charges. If a hospital is not required to prove that it provided unusually costly services to obtain reimbursement under the "stop-loss" exception, then there is no effective cost control provided by the 1997 Fee Guideline.

ARGUMENT

I. Is the "stop-loss" exception in the 1997 Fee Guideline invalid if it fails to provide effective medical cost control? Does the "stop-loss" exception require a two-prong test be met before the "stop-loss" exception reimbursement methodology is applied?

Petitioners assert that the "Stop-Loss" Method is a bright-line reimbursement methodology (Petitioners' BOM *passim* and Petitioners' Consolidated Reply Brief *passim),* a bright-line threshold (Petitioners' BOM at 12, 21), a bright-line rule (Petitioners' BOM at 14 and Petitioners' Consolidated Reply Brief at 22), and a bright-line test. Petitioners' Consolidated Reply Brief at 8. The *Amici Curiae* Texas Hospital Association, *et al.* (*Amici* THA) assert that the "Stop-Loss" Method is a bright-line standard. *Amici* THA Brief in Support of Petition for Review at 4. Petitioners' and *Amici* THA claim that under the "stop-loss" exception hospitals are automatically entitled to reimbursement at seventy-five (75%) percent of "audited charges" if the "audited charges" exceed $40,000. Petitioners' Consolidated Reply Brief at 5 and *Amici* THA Brief in Support of Petition for Review at 3. Petitioners' further claim that insurance carriers' "audit rights" protect insurance carriers' "pecuniary interest in minimizing payments." Petitioners' Consolidated Reply Brief at 12 *citing* Respondent Division's BOM at 40. ICT will address the so called "audit rights" and "protection" *infra*. Petitioners, *Amici* THA and Respondent Division claim that the bright-line reimbursement methodology does not violate Labor Code Section 413.011's statutory standards. Petitioners'

Consolidated Reply Brief at 9-10, *Amici* THA Brief in Support of Petition for Review at 14, and Division BOM at 33.

Petitioners contend there is no need to construe the "stop-loss" exception as its bright-line methodology is clear. Petitioner's contention ignores the primary objective in construing a statute: regardless of ambiguity, one must give effect to legislative intent. *Mitchell Energy Corp. v. Ashworth*, 943 S.W.2d 436, 438 (Tex. 1997); *Hidi v. State and County Mutual Fire Ins. Co.*, 988 S.W.2d (Tex.App.- Austin 1999), *rev'd on other grounds* 13 S.W.3d 767 (Tex. 2000). According to the "Construction of Laws" Act, a court "shall diligently attempt to ascertain legislative intent and shall consider at all times the old law, the evil, and the remedy. TEX. GOV'T CODE § 312.005. When determining legislative intent, according to the "Code Construction Act," *whether or not a statute is considered ambiguous on its face*, a court looks to the object sought to be attained, legislative history, the language of the statute, and the consequences that would flow from alternate constructions. TEX. GOV'T CODE § 311.023 (Emphasis added); *Crown Life Ins. Co. v. Casteel*, 22 S.W.3d 378, 383 (Tex. 2000). Further, in enacting a statute, it is presumed that a "just and reasonable result is intended" and the "public interest is favored over any private interest." TEX. GOV'T CODE § 311.021.

Texas Labor Code Section 413.011 provided Texas Workers' Compensation Commission fee guidelines must be "fair and reasonable" and designed to:

(1) "ensure the quality of medical care; and"

(2) "achieve effective medical cost control;"

(3) "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 by someone acting on that individual's behalf;" and

(4) "consider the increased security of payment afforded" by the Texas Workers' Compensation Act.

TEX. LAB. CODE § 413.011(b).[6]

The Texas Workers' Compensation Commission used "fair and reasonable" as a shorthand reference to the four specific standards set forth above. 22 Tex. Reg. 6295. Since each fee guideline must satisfy all four of these specific statutory standards and must be "designed" to meet them, any interpretation of a fee guideline provision should be tested against all four of these statutory standards. *Pruett v. Harris County Bail Bond Bd.*, 249 S.W.3d 447, 452 (Tex. 2008) *citing Gerst v. Oak Cliff Sav. & Loan Ass'n*, 432 S. W.2d 702, 706 (Tex. 1968).

Petitioners assert that the "stop-loss" exception achieves effective medical cost control since it requires reimbursement of only seventy-five (75%) percent of billed charges "after reductions pursuant to audit." Petitioners' Consolidated Reply Brief at 10. Indeed, on page 14 of Petitioners' BOM, Petitioners assert hospitals only receive sixty-nine (69%) percent of a hospitals' charges. In the example given by Petitioners no mention is made of any costs to the hospital. If, in the example given, the hospital's costs were $10,000 and it billed $108,000 then payment of $74,999.25 results in a profit of

6. *Amended by* Act of June 17, 2001, 77th Leg., R.S., ch. 1456, § 6.02, 2001 Tex. Gen. Laws 1456 (current version at Tex. Lab. Code § 413.011(d)).

$64,999.25. This is approximately a six hundred fifty (650%) percent profit over cost. Understandably, the Commission determined a percentage of billed charges methodology was “unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living.” 22 Tex. Reg. 6276.

It is axiomatic that an agency derives its rulemaking authority solely from its enabling legislation and it has no inherent power to make law. *Sexton v. Mount Olivet Cemetery Ass'n,* 720 S.W. 2d 129 (Tex. App. - Austin 1986, writ ref'd n.r.e.). Likewise "[i]t is well settled that an agency cannot adopt rules that are inconsistent with a statute". *Havner v. Meno,* 867 S.W. 2d 130, 134 (Tex. App. - Austin 1993, no writ) *citing Railroad Comm'n v. Lone Star Gas Co.,* 844 S.W. 2d 679, 685 (Tex. 1992).

A statute sets forth the policy of the State as adopted by the Legislature and establishes the primary standards that must be adhered to by the government and the public. *Tex. Antiquities Comm. v. Dallas County. Community College Dist.,* 554 S.W. 2d 924, 927-928 (Tex. 1977). "[A]n agency can exercise only such authority as is conferred upon it by law in clear and unmistakable terms and that the same will not be construed to be conferred by implication". *Board of Insurance Commissioners v. Guardian Life Insurance Company,* 180 S.W. 2d 906 (Tex. 1944); *Key Western Life Insurance Company v. State Board of Insurance,* 350 S.W. 2d 839 (Tex. 1961). An agency may not exercise

authority that exceeds the clear intent of the legislature, *Gulf Coast Water Co. v. Cartwright,* 160 S.W.2d 269 (Tex. Civ. App. - Galveston 1942, writ ref'd w.o.m.).

If the "stop-loss" exception as interpreted by Petitioners and *Amici* THA does not provide effective medical cost control, then the exception conflicts with the statutory standards and is invalid. The Austin Court of Appeals held that the "stop-loss" exception as interpreted by Petitioners and *Amici* THA does not provide effective medical cost control. *Tex. Mut. Ins. Co. v. Vista Cmty. Med. Ctr., LLP*, 275 S.W.3d 538, 550 (Tex. App. - Austin 2008, pet. filed); 22 Tex. Reg. 6276. This can be seen from the testimony of Vista's corporate representative Jean Wincher (RR 2 66-67), and the testimony of Texas Mutual's witness Ron Luke. RR 2 132-133.

The Commission when proposing the 1997 Fee Guideline considered using a "discount from billed charges" method of determining payments to hospitals. A discount from billed charges is simply paying a percentage of the billed charges. However, the Commission rejected this method because:

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

22 Tex. Reg. 6276.

Even though the Commission rejected paying a percentage of billed charges as failing to provide effective medical cost control, nevertheless, as will be shown *infra* the *En Banc* Panel, and the SOAH ALJs that are deciding alleged "stop-loss" exception cases

under the *En Banc* Panel Decision, are ordering payment of a percentage of billed charges.

Respondent Division contends that Respondent Carriers have made "the novel proposition that an agency rule can become invalid when, retrospectively, it can be argued that application of the rule in some instances no longer 'achieves,' 'meets' or 'provides for' the goals set forth generally by the Legislature in its grant of rule-making authority." Respondent Division BOM at 33. Respondent Division misunderstands the Respondent Carriers' position regarding invalidity. If the "stop-loss" exception is interpreted that hospitals are automatically entitled to reimbursement at seventy-five (75%) percent of "audited charges" if the "audited charges" exceed $40,000, then the Respondent Carriers state the "stop-loss" exception is invalid. If the "stop-loss" exception is interpreted that hospitals are eligible for reimbursement at seventy-five (75%) percent of "audited charges" if the audited charges exceed $40,000, and the admission is shown to be unusually extensive and costly, then the Respondent Carriers state the "stop-loss" exception is valid. Respondent Carriers have never contended that any hospital does not have the right to seek medical dispute resolution before Respondent Division and prove entitlement to "stop-loss" reimbursement. In fact, Respondent Carriers have consistently argued that the burden of proof is on a hospital to meet the unusually extensive and costly prong of the two-prong test.

The Respondent Division agrees that "stop-loss" reimbursement requires meeting a two-prong test. Respondent Division BOM at 16. The Respondent Division further agrees that hospitals must show unusually costly and extensive services to obtain "stop-

loss" reimbursement. Respondent Division BOM at 16-17. The Respondent Division states that "[c]onsideration of the length, cost and extensiveness of hospital services on a case-by-case basis as an independent component part of the stop-loss reimbursement methodology is consistent with these legislative". . . "objectives" that fair and reasonable payments are made and effective medical cost control is achieved. Respondent Division BOM at 19-20.

The Respondent Division then contradicts itself by stating that automatic payment of seventy-five (75%) percent of "audited charges" that exceed $40,000 complies with the statutory standards and is not a unconstitutional private delegation. Respondent Division BOM at 35-36. Respondent Division also contends that hospitals are not allowed to "unilaterally establish fees" (Respondent Division BOM at 37) contradicting the testimony of its representative, former Director of Medical Review and then Director of Information Management Services, Allen McDonald. RR 1 182.

II. Does the example in "stop-loss"exception of the 1997 Fee Guideline support the contentions of Petitioners? Are the claims of Petitioners, *Amici* THA, and Respondent Division regarding a single bright-line reimbursement supported by the Act, rules and record?

Petitioners contend the "stop-loss" exception "Example" removes the requirement to prove entitlement to "stop-loss" reimbursement. Petitioners' Consolidated Reply Brief at 1. Indeed, Petitioner's assert the failure of "Respondents to even" attempt "to walk the Court through the Example provided in the Rule proves Petitioners' claims regarding

application of the stop-loss exception."[7] Actually, Respondent Zurich American Insurance Company (Respondent Zurich) addressed the Example. Respondent Zurich BOM at 8. Respondent Zurich pointed out that the "Example" is a "mathematical calculation should the case so qualify." *Id.* Respondent Zurich pointed out the per diem portion of the 1997 Fee Guideline also contains an example of the mathematical calculation for the per diem. *Id.* The Example is just a mathematical calculation once a determination is made that the "stop-loss" exception applies to a particular bill. Whether an admission is paid under the "stop-loss" method or the per diem method, the payment calculation itself is just a mathematical calculation. Indeed, the Example's mathematical calculation is exactly the same under the Court of Appeals' opinion as under Petitioner's interpretation of the "stop-loss" exception. This case is about whether the "stop-loss" method of reimbursement applies only when an admission results in audited charges greater than $40,000.00 or does the "stop-loss" exception also require that the admission is unusually costly and extensive. This is supported by the testimony of Respondent Division's expert witness, Ms. Hannusch, who, when discussing the different approaches taken by SOAH ALJs and MRDOs, testified: "Do you characterize a particular stop-loss admission before you apply mathematics. That kind of got blurred. . . . [I]n reality you're doing that two-pronged approach for every single medical bill that you ever process. You're always looking at the service that's being billed and then

7. By "Rule" Petitioners refer to the "stop-loss" exception.

comparing it to what the mathematics are and any type of guideline." Joint Exhibit 13 at 22-23

Petitioners' claim the Austin Court of Appeals engaged in a "judicial rewriting" of the "stop-loss" exception. Petitioners' Consolidated Reply Brief at 5, 12, and 15. First, as shown by ICT's Statement of Facts (pages 3 & 4 *supra*), since 1997 through the present, agency staff interpreted the "stop-loss" exception as requiring proof of unusually costly and extensive services. Respondent Division BOM at xi-xii. The majority of SOAH ALJs up through November 2005 interpreted the "stop-loss" exception as requiring proof of unusually costly and extensive services. ICT's Statement of Facts at 5-6 & 22-13. The Austin Court of Appeals' interpretation of the "stop-loss" exception is actually Respondent Division's interpretation as set forth in the Staff Report. *Tex. Mut. Ins. Co. v. Vista Cmty. Med. Ctr., LLP*, 275 S.W.3d 538, 546 (Tex. App. - Austin 2008, pet. filed). As the two-prong test is Respondent Division's interpretation of its own rule, it is entitled to deference so long as that interpretation is reasonable and consistent with the plain language of the rule. *Id.* at 548 citing *Public Util. Comm'n v. Gulf States Utils. Co.*, 809 S.W.2d 201, 207 (Tex. 1991); TEX. GOV'T CODE § 311.023(6). Deference is warranted given: (1) the stated purpose of the 1997 Fee Guideline in the preamble to its adoption; (2) Respondent Division's general rejection of charge-based payments and recognition that charges are not a good indicator of costs; and (3) the language in Subsection (c)(6)(ii) of the 1997 Fee Guideline.

Petitioners' claim the Commission "based its Rule" on managed care contracts reviewed by the Commission. (Petitioners' Consolidated Reply Brief at 8, 11, and 15. *Amici* THA claims the Austin Court of Appeals' interpretation is contrary to the "industry practice on which the Rule was based." *Amici* THA Brief in Support of Petition for Review at 3. However, these claims are incorrect. The Commission's Medical Advisory Committee recommended to the Commission *the proposal* of the 1997 Fee Guideline as it was eventually published in the July 26, 1996, Texas Register "based on the same methodology (*use of hospital contract rates*)." 22 Tex. Reg. 6265. (Emphasis added). "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." *Id.* The Preamble makes it clear the Commission used data from the managed care contracts, but the Commission repeatedly stated in the Preamble that the statutory requirements made other elements necessary in its analysis of the data--one of those elements was cost. 22 Tex. Reg. 6265. The Commission had to comply with the statutory standards in Labor Code Section 413.011(b). ICT is unaware of any managed care contract being based on the statutory standards. ICT is also unaware of any managed care contract reviewed by the Commission being in the record of this case. So when *Amici* THA assert (1) the "Stop-Loss Rule tracks stop-loss provisions common in hospital managed care contracts,"*(Amici*

THA Brief in Support of Petition for Review at 6), or (2) the "Stop-Loss Rule was expressly patterned after similar provisions in the managed care contracts reviewed by the agency,"(*id.*), there is no proof of those assertions. Indeed the quoted remarks found on page 7 of *Amici* THA's Brief in Support of Petition for Review show the Commission relied upon the managed care contract *rates* as stated *supra.* 22 Tex. Reg. 6265.

Petitioners and *Amici* THA contend that their interpretation of the "stop-loss" exception follows the plain language of the exception. They contend that "audited charges" that exceed $40,000 are proof of unusually costly and extensive services. However, when adopting the 1997 Fee Guideline, as stated *supra,* the Commission relying on statements by the hospitals themselves, found that hospitals' billed charges did not have "a consistent, and rational relationship to either payments accepted by hospitals for services *or to hospital costs*." 22 Tex. Reg. 6292. (Emphasis added).

Amici THA contends that because the Commission did not mention the terms "unusually costly" or "unusually extensive"in the preamble to the adoption of the 1997 Fee Guideline, it was not the Commission's intent to require such a showing to obtain "stop-loss" reimbursement. *Amici* THA Brief in Support of Petition for Review at 5. This ignores the plain language of the exception. As Respondent Zurich has stated in its BOM at 9, "[t]he whole point is that those words ARE actually in the Rule."

Petitioners claim that the 1997 Fee Guideline "stop-loss" exception was not intended to minimize disputes as unambiguously stated in the Preamble (22 Tex. Reg. 6285) but instead was designed to eliminate all disputes. Petitioners' Consolidated Reply

Brief at 8-9. Petitioners ignore Labor Code Sections 408.027(e) (insurance carrier entitled to hearing as provided by Section 413.031(d)), and 413.031(k) (a party to a medical dispute is entitled to a hearing). Petitioners also contend that under Respondent carriers' interpretation, the unusually costly and extensive nature of a particular admission could only be considered when charges exceed $40,000 and that this situation creates an unfair "one-way street." Petitioners' Consolidated Reply Brief at 13-14. There is no one-way street or unfairness. The minimum charge threshold for application of the "stop-loss" method is $40,000, but this minimum "stop-loss" threshold does not preclude consideration of unusually costly or extensive services as a reasonable justification for deviation from the 1997 Fee Guideline when minor injuries result in large bills that are less than $40,000. Labor Code Section 413.031(b) has long provided that if a fee guideline does not provide adequate reimbursement in a particular case, the health care provider may seek a payment in excess of the fee guideline amount. Contrary to the Petitioners' hypothetical, the hospital that provided unusually costly services for a nail puncture, but billed only $35,000, would not be limited to the 1997 Fee Guideline payment. Petitioners' Consolidated Reply Brief at 13. Rather, the hospital could seek an award of additional compensation from Respondent Division by demonstrating that it provided unusually costly and extensive services which may be a reasonable justification for deviation from the 1997 Guideline given the nature of the injury.

Petitioners contend that the Austin Court of Appeals' interpretation of the "stop-loss" exception will erode the quality of care. Petitioners' Consolidated Reply Brief at10.

Amici THA contend that the Court's interpretation will limit injured worker access to care. *Amici* THA Brief in Support of Petition for Review at 14-15. There is no proof of Petitioners' contention in the record. Petitioners (Petitioners' Consolidated Reply Brief at10) and *Amici* THA (THA Brief in Support of Petition for Review at 14) contend that the "stop-loss" exception was necessary to balance the per diem amounts. However, the Commission changed the per diem amounts to ensure access to quality care. 22 Tex. Reg. 6267. Again, contrary to Petitioners' and *Amici* THA's contention regarding access to care, Vista is continuing to accept workers' compensation patients even under the new Medicare based Hospital Facility Fee Guideline-Inpatient (28 TEX. ADMIN. CODE § 134.404)! (Appendix 5).

III. Does the Act or agency's rules prevent a hospital from determining its own charges for services and items provided prior to March 1, 2008? Do the agency's audit rules allow insurance carriers to reduce a hospital's charge to a fair and reasonable amount?

A. Usual and Customary

The terms "usual and customary" are not coupled with health care provider charges in the Labor Code. In other words the Labor Code does not specifically state that a health care provider is to bill its usual and customary charges to insurance carriers. Labor Code Section 415.005, after amendment, provides:

> (a) A health care provider commits a violation if the person charges an insurance carrier an amount greater than that normally charged for similar treatment to a payor outside the workers' compensation system, except for mandated or negotiated charges.
>
> (b) A violation under this section is an administrative violation. A health care

provider may be liable for an administrative penalty regardless of whether a criminal action is initiated under Section 413.043.

This section makes it an administrative violation for the health care provider to charge an insurance carrier an amount greater than that normally charged by the health care provider for similar treatment to a payor outside the workers' compensation system. TEX. LAB. CODE § 415.005. However, the agency's rules require *and* required all health care providers (including hospitals) to bill their "usual and customary" charges. 28 TEX. ADMIN. CODE §§ 134.401(b)(2)(A), 134.801(g)(1) now 133.20(e)(1). A medical bill must be submitted: (1) for an amount that does not exceed the health care provider's usual and customary charge for the health care provided in accordance with Labor Code §§413.011 and 415.005. . . ." 28 TEX. ADMIN. CODE § 133.20(e)(1). Under the 1997 Fee Guideline, the hospital determined its own charges. Vista's corporate representative Jean Wincher testified that Vista employees determine the amounts on the chargemaster Vista used to bill insurance carriers. RR 2 62. The Division's corporate representative Allen McDonald also testified that a hospital determines the amounts on its chargemaster to bill the insurance carrier. RR 1 186 & 189-190. Ms. Wincher also testified that nothing prevented any hospital from increasing its' charges as it saw fit. RR 2 66-67. Mr. McDonald also testified that nothing prevented any hospital from increasing its' charges as it chose to do so. RR 2 189-190. Texas Mutual's witness, Ron Luke, testified there was no governmental control over how high a hospital set its charges nor were hospitals charges constrained by competition. RR 2 132-133. Allen McDonald testified that the *En*

Banc Panel had rejected any contention that a hospital's usual and customary charge was anything other than what that hospital charged for an item or service. RR 1 139. Mr. McDonald further testified he was unaware of any hospital being charged with any criminal violation or administrative violation for charging more than some other hospital for an item or service. RR 1 185-186. Nothing in the Act or agency's rules prevents a hospital from determining the amount of its charges for its services and items.

Besides the *En Banc* Panel, other SOAH ALJs have concluded that carriers are limited to audit the hospitals' billed charges only to that specific hospital's usual and customary charge. *See San Antonio I.S.D. v. Metropolitan Meth. Hosp*., SOAH Docket No. 452-03-1233.M4 at 10 (ALJ Walston, Oct. 9, 2003)(Appendix 6); *American Home Assurance Co. v. Baylor Univ. Med. Ctr*., SOAH Docket No. 453-04-4223.M4 at 4-6 (ALJ Card, August 19, 2004)(Appendix 7); *Dillards' Dep't. Stores v. Huguley Memorial Hosp*., SOAH Docket No. 453-04-3600.M4 at 8 (ALJ Church, Nov. 2, 2004)(Appendix 8).

B. Carrier Audit Rights

"Audited charges" are defined as "those charges which remain after a bill review by the insurance carrier has been performed." 28 TEX. ADMIN. CODE § 134.401(c)(6)(A)(v).[8] The "stop-loss" exception itself allows deduction of charges for

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

personal items. *Id.* Other generally applicable Texas Workers' Compensation Commission, now Texas Department of Insurance, Division of Workers' Compensation audit rules allow the carrier to review bills for consistency with fee and treatment guidelines, duplicate billing, improper or inaccurate coding, incorrect calculations, and medical necessity among other things. 28 TEX. ADMIN. CODE § 133.301(a) (repealed effective May 2, 2006); 28 TEX. ADMIN. CODE § 133.230 (effective May 2, 2006). The *En Banc* Panel held that "Carriers' audit rights are not limited by § 134.401(c)(6)(A)(v) when the stop-loss reimbursement methodology applies. In such cases, carriers may audit in accordance with § 134.401(b)(2)(C). Joint Exhibit 2-1 at p. 15-16 (pages 12 and 13 of the Order). Subsection (b)(2)(C) provided "[a]ll charges submitted are subject to audit as described in Commission rules." Former rule 133.301(a) provided in part: "[t]he insurance carrier *shall* retrospectively review all complete medical bills and *pay for* or deny payment for *medical benefits in accordance with the Act*, rules, and the appropriate Division fee and treatment guidelines." 31 Tex. Reg. 1539 (2006) (emerg. rule 28 TEX. ADMIN. CODE § 133.301) (adopted Mar. 10, 2006, expired May 1, 2006) (Tex. Dept. of Ins.), 25 Tex. Reg. 2128 (March 10, 2000), proposed 24 Tex. Reg. 10286 (November 19, 1999). "The 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).

Id.

The use of the words "shall retrospectively review all complete medical bills and *pay* for or deny payment for" in former rule 133.301(a) connotes a mandatory directive to pay according to the Labor Code and the rules adopted there under. *Moseley v. Behringer,* 184 S.W.3d 829, 833 (Tex. App. - Fort Worth 2006, no pet.); *Hawkins v. Dallas County Hosp. Dist.*, 150 S.W.3d 535, 540-41 (Tex. App.- Austin 2004, no pet.); TEX. GOV'T CODE § 311.016(2). In other words, regardless of the reimbursement methodology used, the statutory standards must be met. Any reimbursement contrary to the statutory standards is invalid. Another of the Commission's former rules, Rule 133.304, Medical Payments and Denials, provided in part:

(e) Within seven days of completing an onsite audit performed in accordance with § 133.303, the insurance carrier shall take final action on the bill, consistent with the results of the audit.

(f) The insurance carrier shall send a copy of the explanation of benefits to the injured employee at the same time it is sent to the sender of the bill if the insurance carrier has reduced or denied payment for a charge on the bill because the insurance carrier believes that treatment(s) and/or service(s) were:

(1) unreasonable and/or unnecessary;

(2) provided by a health care provider other than

(A) the treating doctor selected in accordance with § 408.022 of the Texas Labor Code,

(B) a health care provider that the treating doctor has chosen as a consulting or referral provider,

(C) a doctor performing a required medical examination in accordance with § 126.5 of this title (relating to Procedure for Requesting Required Medical Examinations) and § 126.6 of this title (relating to Order for Required Medical Examinations), or

(D) a doctor performing a designated doctor examination in accordance with § 130.6 of this title (relating to Designated Doctor: General Provisions); or

(3) unrelated to the compensable injury, in accordance with § 124.2 of this title (relating to Carrier Reporting and Notification Requirements).

Repealed 31 Tex. Reg. 3544 (Apr. 28, 2006), 30 Tex. Reg. 762131 (2006) (emerg. rule 28 Tex. Admin. Code § 133.304) (adopted Nov. 18, 2005), adopted, 28 Tex. Reg. 7810 (Sep. 5, 2003), adopted 25 Tex. Reg. 2128 (Mar. 10, 2000), proposed 24 Tex. Reg. 10286 (Nov. 19, 1999).

Subsection (i) of Rule 133.304 required insurance carriers to make fair and reasonable reimbursements to health care providers for their services and treatments when there was no maximum allowable reimbursement (MAR).[9] *Tex. Workers' Comp. Comm'n*

9. Former Rule 133.304 (i) provided: When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

(1) develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar

v. Patient Advocates, 136 S.W.3d 643, 656 (Tex. 2004); 24 Tex. Reg. 10286 (1999), adopted 25 Tex. Reg. 2128 (2000), amended by 30 Tex. Reg. 7621 (2005) (emerg. rule); adopted 31 Tex. Reg. 3544 (2006). Legislative and agency policy has consistently provided that insurance carriers make fair and reasonable reimbursements to hospitals.[10] But as held by the *En Banc* Panel, carriers are only "allowed to audit" by rule 133.301(a) such "items as incorrect calculations, upcoding, unbundling, and duplicate billing." Joint Exhibit 2-1 at p. 16 (page 13 of the Order). This holding limited the carriers' audit preventing compliance with former rule 133.304(i) and the specific statutory provisions of Labor Code Section 413.011(d) cited above. As held in *State v. Public Util. Comm'n of Tex*., 131 S.W.3d 314, 321 (Tex. App.- Austin 2004, pet. denied), an agency may not "contravene specific statutory language, run counter to the general objectives of the statute, or impose additional burdens, conditions, or restrictions in excess of or inconsistent with the relevant statutory provisions

---

circumstances receive similar reimbursement;

(2) explain and document the method it used to calculate the rate of pay, and apply this method consistently;

(3) reference its method in the claim file; and

(4) explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement.

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

Allen McDonald was asked if there was any provision in the Act, the agency's rules, or any publication authorizing an insurance carrier to reduce the amount of a hospital's usual and customary charge for an item or service. Mr. McDonald testified he was unaware of any such legal authority. RR 2 139. Mr. McDonald also testified that it was the agency's position that an insurance carrier could not reduce a hospital's charges for implants to cost plus ten (10%) percent. RR 2 149-150. He went on to testify that if the *En Banc* Panel was correct that a hospital's usual and customary charge was what that particular hospital charged for an item or service, then an insurance carrier could not reduce a hospital's usual and customary charge. RR 2 142-143. Mr. McDonald also testified that if an insurance carrier could not audit a hospital's charge down to a geographic area customary charge, then the hospital would be setting its own reimbursement amount. RR 1 190.[11]

C. SOAH's Treatment of Carrier Audits

Since the *En Banc* Panel Decision, SOAH has repeatedly refused to allow insurance carriers to reduce hospital charges to a fair and reasonable amount. See for example: *Rio Grande Regional Hospital v. Texas Mutual Insurance Company,* SOAH Docket No. 453-05-9670.M4 (ALJs Seitzman & Broyles, Aug. 9, 2007)(Appendix 10); *Pacific Employers Insurance Company v. Vista Medical Center Hospital*, SOAH Docket

11. On February 23, 2007, in a letter from ALJ Catherine C. Egan to "All PARTIES OF RECORD" ALJ Egan stated that the *En Banc* Panel's position is that "a hospital's usual and customary" is clear. "They refer to the hospital's own 'usual and customary charges' and do not refer to any other charges such as an average or median of other hospitals' charges." (Appendix 9).

No. 453-05-2804.M5 (ALJ Norman, Jan. 7, 2008)(Appendix 11); *Ace Insurance Company of Texas v. Vista Medical Center Hospital*, SOAH Docket No. 453-05-9025.M5 (ALJ Broyles, May 22, 2008)(Appendix 12); *Ace Insurance Company of Texas v. Vista Medical Center Hospital*, SOAH Docket No. 453-05-7487.M4 (ALJ Broyles, July 1, 2008)(Appendix 13); *Vista Medical Center Hospital v. Pacific Employers Insurance Company*, SOAH Docket No. 453-05-9178.M4 (ALJ Norman, July 11, 2008)(Appendix 14); *Vista Medical Center Hospital v. Pacific Employers Insurance Company*, SOAH Docket No. 453-05-5471.M4 (ALJ Norman, July 11, 2008)(Appendix 15). The foregoing cases show the illusion of a carrier being able through an audit of a hospitals' bill to reduce the hospital's charges to a fair and reasonable amount.

D. Commission's Treatment of Carrier Audits

Prior to the Staff Report the Commission's Medical Dispute Resolution Officers (MDROs) took inconsistent positions on the scope of a carrier's audit. Some MDROs would allow a reduction to cost plus ten (10%) percent of a hospital's charge for an implantable. However, others refused to allow insurance carriers to reduce any hospital charges to a fair and reasonable amount. See for example: MDR Tracking No. M4-03-0252-01, decided October 13, 2004 (Appendix 16); MDR Tracking No. M4-03-0775-01, decided February 12, 2004 (Appendix 17); MDR Tracking No. M4-02-4838-01, decided April 4, 2003 (Appendix 18); MDR Tracking No. M4-03-0277-01, decided November 21, 2002 (Appendix 19). As stated *supra* the Respondent Division's representative Mr. McDonald testified an insurance carrier did not have the legal authority to reduce the

amount of a hospital's usual and customary charge for an item or service. RR 2 139.

The Austin Court of Appeals affirmed the trial courts' judgment that carriers may not reduce the charges for implantables, orthotics, and prosthetics to cost plus ten (10%) percent when determining whether the "stop-loss" exception applies. *Tex. Mut. Ins. Co. v. Vista Cmty. Med. Ctr., LLP*, 275 S.W.3d at 557. The Austin Court of Appeals' interpretation of the "stop-loss" exception is the same as set forth in the Staff Report. *Tex. Mut. Ins. Co. v. Vista Cmty. Med. Ctr., LLP*, 275 S.W.3d at 546 (Tex. App. - Austin 2008, pet. filed). In *Mid-Century Insurance Company v. Texas Workers' Compensation Commission*, 187 S.W.3d 754, 758 (Tex. App. – Austin 2006, no pet.), the Austin Court of Appeals held "that an agency's construction of a statute within its area of expertise should be given serious consideration . . . as long as the construction is reasonable and does not contradict the statute's plain language. *See AT&T Communications of Tex. L.P. v. Southwestern Bell Tel. Co.*, No. 03-0789, 2006 Tex. LEXIS 93, at *33-34 (Tex. Jan. 27, 2006) (stating that an agency is entitled to 'some deference' in construing statutes affecting its jurisdiction as long as the construction is reasonable); *Southwestern Life Ins. Co. v. Montemayor*, 24 S.W.3d 581, 585 (Tex. App. - Austin 2000, pet. denied); see also *Texas Gen. Indem. Co. v. Eisler*, 981 S.W.2d 744, 747 n.2 (Tex. App.-Houston [1st Dist.] 1998, no pet.)."

CONCLUSION AND PRAYER

The Insurance Council of Texas joins Texas Mutual Insurance Company, Zenith Insurance Company, Liberty Mutual Insurance Company, and Zurich American Insurance

Company in praying this Court to deny the petition for review filed by Vista Community Medical Center, L.L.P. and Christus Health Gulf Coast. If the Court grants the petition for review, the Insurance Council of Texas respectfully urges the Court to affirm the judgment of the Court of Appeals, or in the alternative, declare the "stop-loss" exception invalid.

Respectfully submitted,

JOHN D.PRINGLE, P.C.
The Vaughn Building
807 Brazos, Suite 200
Austin, Texas 78701
(512) 472-8742
(512) 472-8745 (FAX)

By:___________________________________
John D. Pringle
State Bar No. 16330300

ATTORNEY FOR INSURANCE COUNCIL OF TEXAS

CERTIFICATE OF SERVICE

I hereby certify that I have on this the 9th day of December, 2009, served a copy of the foregoing **Brief of Amicus Curiae Insurance Council of Texas** by certified mail, return receipt requested, and/or first class mail, and/or hand-delivery, and/or facsimile transmission, and/or overnight delivery to all parties through the following counsel:

David F. Bragg — Via Certified Mail No. 7008 11440 0004 9611 5535
LAW OFFICE OF DAVID F. BRAGG, P.C.
211 East Seventh Street, Suite 920
Austin, Texas 78701

Eric Carter — Via Certified Mail No. 7008 1140 0004 9611 5542
THE CARTER LAW FIRM
1314 Texas Avenue, Suite 1110
Houston, Texas 77002

P.M. Schenkkan — Via Certified Mail No. 7008 1140 0004 9611 5559
Thomas B. Hudson, Jr.
Christopher H. Trickey
GRAVES, DOUGHERTY, HEARON & MOODY
401 Congress Avenue, Suite 2200
Austin, Texas 78701

Dudley D. McCalla — Via Certified Mail No. 7008 1140 0004 9611 5566
HEATH, DAVIS & MCCALLA, P.C.
720 Brazos Street, Suite 200
Austin, Texas 78701

Robert F. Josey — Via Certified Mail No. 7008 1140 0004 9611 5573
Catherine L. Hanna
HANNA & PLAUT, L.L.P.
The Littlefield Building
106 East Sixth Street, Suite 600
Austin, Texas 78701

J. Stephen Ravel — Via Certified Mail No. 7008 1140 0004 9611 5580
Holly Vandrovec
KELLY HART & HALLMAN, LLP
301 Congress Ave., Suite 2000
Austin, Texas 78701

James M. Loughlin Via Certified Mail No. 7008 1140 0004 9611 5597
STONE LOUGHLIN & SWANSON, LLP
P. O. Box 30111
Austin, Texas 78755

Steven M. Tipton Via Certified Mail No. 7008 1140 0004 9611 5603
FLAHIVE, OGDEN & LATSON
P.O. Drawer 13367
Austin, Texas 78711

T. Daniel Holloway Via Certified Mail No. 7008 1140 0004 9611 5610
James G. Gumbert
HOLLOWAY & GUMBERT, P.C.
3701 Kirby Dr., Suite 1288
Houston, Texas 77098-3926

Nicholas Canaday, III Via Certified Mail No. 7008 1140 0004 9611 5627
Assistant Attorney General
Administrative Law Division
P.O. Box 12548
Austin, Texas 78711-2548

Laura B. Fountain Via Certified Mail No. 7008 1140 0004 9611 5634
Assistant Attorney General
Tort Litigation Division
P.O. Box 12548
Austin, Texas 78711

Douglas W. Alexander Via Certified Mail No. 7008 1140 0004 9611 5641
ALEXANDER DUBOSE & TOWNSEND, LLP
Bank of America Center
515 Congress, Ave., Suite 2350
Austin, Texas 78701

Mary Barrow Nichols Via Certified Mail No. 7008 1140 0004 9611 5658
TEXAS MUTUAL INSURANCE CO.
6210 E. Hwy. 290
Austin, Texas 78723

Pamela Stanton Baron
ATTORNEY AT LAW
P.O. Box 5573
Austin, Texas 78763

Via Certified Mail No. 7008 1140 0004 9611 5665

By:______________________________

John D. Pringle

APPENDIX

Joinder Order No, 1 Abating Case . . . . Tab 1

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

Texas Mutual Insurance Company's Comments and Insurance Council
of Texas Supplemental Comments on Proposed Repeal of the
1997 Hospital Fee Guideline . . . . Tab 3

John D. Pringle Comments on Proposed Repeal of the
1997 Hospital Fee Guideline . . . . Tab 4

Dynacq Healthcare, Inc. SEC Form 10-K for fiscal year 2009 . . . . Tab 5

SOAH Docket No. 452-03-1233.M4; *San Antonio I.S.D. v.*
Metropolitan Meth. Hosp. . . . . Tab 6

SOAH Docket No. 453-04-4223.M4; *American Home Assurance Co. v.*
Baylor Univ. Med. Ctr. . . . . Tab 7

SOAH Docket No. 453-04-3600.M4; *Dillards' Dep't. Stores v. Huguley*
Memorial Hosp. . . . . Tab 8

SOAH Docket No. 453-03-1487.M4; *Hartford Casualty Insurance*
Company v. Vista Healthcare, Inc.; ALJ Egan letter of February 23, 2007 . . . . Tab 9

SOAH Docket No. 453-05-9670.M4; *Rio Grande Regional Hospital v.*
Texas Mutual Insurance Company . . . . Tab 10

SOAH Docket No. 453-05-2804.M5; *Pacific Employers Insurance Company*
v. Vista Medical Center Hospital . . . . Tab 11

SOAH Docket No. 453-05-9025.M5; *Ace Insurance Company of Texas v.*
Vista Medical Center Hospital . . . . Tab 12

SOAH Docket No. 453-05-7487.M4; *Ace Insurance Company of Texas v.*
Vista Medical Center Hospital . . . . Tab 13

SOAH Docket No. 453-05-9178.M4; *Vista Medical Center Hospital v. Pacific Employers Insurance Company* . . . . Tab 14

SOAH Docket No. 453-05-5471.M4; *Vista Medical Center Hospital v. Pacific Employers Insurance Company* . . . . Tab 15

MDR Track No. M4-03-0252-01, decided October 13, 2004 . . . . Tab 16

MDR Tracking No. M4-03-0775-01, decided February 12, 2004 . . . . Tab 17

MDR Tracking No. M4-02-4838-01, decided April 4, 2003 . . . . Tab 18

MDR Tracking No. M4-03-0277-01, decided November 21, 2002 . . . . Tab 19