SOAH DOCKET NO. 454-13-5437.M4
DWC NO.

SIERRA MEDICAL CENTER, Petitioner	§ § §	**BEFORE THE STATE OFFICE**
v.	§ §	**OF**
CALIFORNIA INSURANCE COMPANY, Respondent	§ § §	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Sierra Medical Center (Provider) challenges the Texas Department of Insurance, Division of Workers' Compensation (DWC) Medical Fee Dispute Resolution Findings and Decision of July 16, 2013 (Decision) denying additional reimbursement to Provider. The Administrative Law Judge (ALJ) finds that Provider has shown itself entitled to additional reimbursement in the amount of $1,075.80, and the ALJ orders California Insurance Company (Carrier) to reimburse Provider this amount.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

This case arises out of the trauma admission on of an injured worker (Claimant) whose workers' compensation insurance was provided by Carrier. Claimant suffered a traumatic hand injury requiring the partial amputation of one of his fingers. He was admitted to Provider's facility early in the morning and was released later that day—after being in the facility approximately 14 hours and undergoing surgery. Provider submitted a bill for $15,914.75 for its services (which excluded the surgeon's charges), and Carrier reimbursed $910.10, which represented the hospital inpatient per diem amount minus a negotiated contract discount that was applied erroneously. Unable to agree on a proper reimbursement for the services provided, Provider timely filed a request for Medical Fee Dispute Resolution (MFDR).

After conducting MFDR, DWC denied Provider's request for additional reimbursement. Provider timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the Decision. An evidentiary hearing was convened before ALJ Craig R. Bennett on September 16, 2013, at SOAH's facilities in Austin, Texas. Provider appeared and was represented by attorney P. Matthew O'Neil. Carrier appeared and was represented by attorney Erin Hacker Shanley. The record closed upon conclusion of the hearing on September 16, 2013.

II. DISCUSSION

The sole issue in this case involves the proper reimbursement for facility charges associated with Claimant's trauma admission and related surgery on 7. To resolve this issue, the ALJ must first determine whether the procedure should be classified as inpatient or outpatient. The proper reimbursement amount will vary based upon this classification. Then, once this determination is made, the ALJ must determine the fair and reasonable reimbursement amount based upon that classification.

A. The Parties' Arguments

Provider argues that Claimant's procedure should be classified as inpatient because he suffered a major injury to his hand that required him staying in the hospital all day and undergoing an amputation surgery. Provider notes that Carrier originally reimbursed this as an inpatient procedure, but incorrectly used the inpatient per diem under the hospital fee guideline, rather than reimbursing the fair and reasonable amount. Provider asserts that there are two potentially correct methods for reimbursing for the facility charges: (1) the Medicare reimbursement amount, which is $5,891.45; or (2) the current DWC guideline amount (calculated at 143% of the Medicare reimbursement for inpatient services), which is $8,424.77. Provider argues that the DWC reimbursement is the most appropriate but, at a minimum, it is entitled to receive the Medicare reimbursement of $5,891.45.

Carrier disagrees, and contends that Provider has erroneously billed the charges as an inpatient procedure when it actually was an outpatient procedure. Carrier argues that the workers' compensation guidelines in existence at the time of the services defined inpatient stays as only those lasting longer than 23 hours.[1] In this case, Claimant was in the facility for only 14 hours during one day—without an overnight stay. Accordingly, Carrier argues that the services must be billed as outpatient.

In terms of the fair and reasonable reimbursement amount for the outpatient services, Carrier notes that the Medicare reimbursement at the time for the billed services was $992.95, which is comparable to the $910.10 that has already been paid. Alternately, Carrier notes that current DWC guidelines allow for reimbursement at 200% of the Medicare reimbursement amount for outpatient services. Using the Medicare reimbursement at the time (which was $992.95, as noted above), Carrier argues this results in a total maximum reimbursement of $1,985.90.[2]

B. The ALJ's Analysis and Conclusion

The ALJ finds that the services in issue should be classified as outpatient. The workers' compensation guidelines in effect when the services were provided required a stay in excess of 23 hours to qualify as an inpatient stay. Thus, Claimant's admission for 14 hours is properly classified as an outpatient procedure.

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[1] 28 Tex. Admin. Code § 134.401(b)(1)(B) (repealed July 13, 2008).

[2] Carrier also cites to alternative calculations based upon the physician's billed CPT codes, but the ALJ finds these unpersuasive, as the CPT codes billed by physicians are different than the codes used by facilities for facility charges. Further, the ALJ disagrees with Carrier's assertion that the procedure did not involve an amputation and, thus, the billing code used by Provider was incorrect. The medical records reflect that part of Claimant's finger was indeed removed because the remaining skin was insufficient to cover the remaining bone.

The ALJ further finds that the law in effect at the time required that these charges be reimbursed at a fair and reasonable amount. Carrier has currently reimbursed only $910.10, which is less than the Medicare reimbursement at the time for the services. An amount less than the Medicare reimbursement is not fair and reasonable, so Provider has shown that the current reimbursement paid is inadequate.

But, the ALJ must also determine from the record what amount is a fair and reasonable reimbursement for the outpatient services provided to Claimant. While not directly applicable, the current DWC guidelines have determined that 200% of Medicare reimbursement is an appropriate reimbursement for these types of outpatient charges. In the absence of other evidence to the contrary, the ALJ finds the current DWC guidelines persuasive and concludes that 200% of the Medicare reimbursement at the time of the services represents a fair and reasonable amount. This results in a total reimbursement of $1,985.90. After subtracting the $910.10 already paid by Carrier, this leaves an outstanding balance of $1,075.80 that is owed by Carrier to Provider for the outpatient services in dispute. By this decision, the ALJ orders that Carrier pay this amount. In support of this decision, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. Sierra Medical Center (Provider) provided outpatient hospital surgical services in El Paso, Texas, to an injured worker (Claimant) on . California Insurance Company (Carrier) was the responsible workers' compensation insurer.

2. Claimant suffered a traumatic hand injury requiring the partial amputation of one of his fingers. He was admitted to Provider's facility early in the morning and was released later that day—after being in the facility approximately 14 hours and undergoing surgery.

3. Provider submitted a bill for $15,914.75 for the services it provided to Claimant, and Carrier reimbursed $910.10.

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4. Unable to agree with Carrier on reimbursement for the services provided, Provider timely filed a request for Medical Fee Dispute Resolution (MFDR) with the Texas Department of Insurance, Division of Workers' Compensation (DWC).

5. DWC issued its MFDR Findings and Decision on July 16, 2013 (Decision).

6. The Decision found that no additional reimbursement was required.

7. Provider timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the Decision.

8. A Notice of Hearing was issued informing the parties of the date, time, and location of the hearing; the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

9. An evidentiary hearing convened on September 16, 2013, before Administrative Law Judge Craig R. Bennett at SOAH's facilities in Austin, Texas. Provider appeared and was represented by attorney P. Matthew O'Neil. Carrier appeared and was represented by attorney Erin Hacker Shanley.

10. The record closed at the conclusion of the hearing on September 16, 2013.

11. The services provided to Claimant by Provider were outpatient services.

12. The Medicare reimbursement for the services in dispute, at the time the services were provided, was $992.95.

13. Current DWC guidelines allow for reimbursement at 200% of the Medicare reimbursement amount for outpatient services.

14. The amount of $1,985.90, which represents 200% of the Medicare reimbursement for the services in issue, is fair and reasonable reimbursement for the outpatient services provided to Claimant by Provider.

IV. CONCLUSIONS OF LAW

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

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

3. Provider has the burden of proving by a preponderance of the evidence that it is entitled to additional reimbursement.

4. Provider has proven by a preponderance of the evidence that it is entitled to additional reimbursement from Carrier for the services provided to the Claimant.

5. Provider is entitled to additional reimbursement from Carrier in the amount of $1,075.80 for the services provided to the Claimant.

ORDER

IT IS ORDERED that California Insurance Company shall pay Sierra Medical Center additional reimbursement of $1,075.80 for the services provided to the injured worker.

SIGNED October 21, 2013.

CRAIG R. BENNETT
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

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