09-0162

In the Supreme Court of Texas

VISTA COMMUNITY MEDICAL CENTER, LLP, AND
CHRISTUS HEALTH GULF COAST,
Petitioners,

v.

TEXAS MUTUAL INSURANCE COMPANY, LIBERTY MUTUAL INSURANCE COMPANY,
ZENITH INSURANCE COMPANY, ZURICH AMERICAN INSURANCE COMPANY, AND
TEXAS DEPARTMENT OF INSURANCE, WORKERS' COMPENSATION DIVISION,
Respondents.

On Petition for Review from the
Third Court of Appeals at Austin, Texas

AMICI CURIAE BRIEF OF THE METHODIST HOSPITAL; PATIENTS MEDICAL CENTER; DOCTORS HOSPITAL 1997, L.P., D/B/A DOCTORS HOSPITAL TIDWELL; AND COVENANT HEALTH SYSTEM

DON CRUSE
State Bar No. 24040744
LAW OFFICE OF DON CRUSE
1108 Lavaca Street, #110-436
Austin, Texas 78701
[Tel.] (512) 853-9100
[Fax] (512) 870-9002
[Email] don@doncruse.com

Counsel for Amici Curiae

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STATEMENT OF INTEREST OF AMICI CURIAE

The *amici* who join this brief are hospitals with unpaid stop-loss claims.[1] And several *amici* have already been sued for a refund of previous stop-loss payments.

The *amici* come from a broad slice of Texas hospitals and hospital systems. One is a university teaching hospital that is a flagship of a Houston-area hospital system. Another serves predominantly Medicaid and Medicare patients in a less affluent area. Still another is a smaller, physician-owned hospital. The brief is also joined by a Lubbock-based hospital system that provides medical care across many rural counties.

The Methodist Hospital in the Texas Medical Center, located in Houston, opened its doors in 1919 and is now a teaching hospital affiliated with Weill Medical College of Cornell University. It is a component of the Methodist Hospital System, which in addition to offering high-quality care, earned a spot in the top 20 of Fortune Magazine's "100 Best Companies To Work For." Methodist Hospital has over $900,000 in pending stop-loss claims; it has also been sued for a refund of prior stop-loss payments.

Patients Medical Center is a physician-owned acute-care hospital that offers medical and surgical services to residents of Pasadena, Deer Park, La Porte, and Clear Lake. It has 61 beds and has 250 physicians on staff, representing more than 28 specialties. Patients Medical Center has over $226,000 in pending stop-loss claims.

Doctors Hospital 1997, L.P., known as Doctors Hospital, provides care to a medically underserved area of North Houston. Its patient population relies greatly on Medicaid and Medicare reimbursements for health care. It has pending stop-loss claims

[1] No one other than the named *amici* is paying for the preparation of this brief.

of approximately $612,000, and in addition is defending against lawsuits demanding that it dip into its budget to refund some of the stop-loss payments it has previously received.

Covenant Health System is based in Lubbock. It consists of four cornerstone hospitals, fourteen leased and managed community hospitals, and twenty smaller healthcare centers that collectively serve a 62-county area across West Texas and Eastern New Mexico. Covenant has approximately $265,000 in pending stop-loss claims; it has also been sued for a refund of some stop-loss payments already received.

* * * * *

The court of appeals' erroneous and unclear decision will be of central importance in approximately 1,500 stop-loss fee disputes with a value between $80 and $300 million (depending on who you ask). It affects a wide range of Texas hospitals, most of which have only a small slice of the larger pie.

The onerous, fact-intensive process imagined by the court of appeals is a sharp break from the simple formula promised by the Fee Guideline. It might be overcome by the handful of hospitals with enough specialization in workers compensation to make a protracted fight with insurers worthwhile. But smaller hospitals may struggle with the process, and with defending lawsuits that ask them to reach into hospital budgets to write refund checks for previous stop-loss payments.

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TO THE HONORABLE SUPREME COURT OF TEXAS:

The decision below breaks the 1997 Fee Guideline. It transforms a clear formula into one so murky that even the Respondents can't say if it now has two elements or three, or agree what factors are to be evaluated. The inexorable result will be confusion in the 1,500 stop-loss fee disputes pending below, compounded by new refund suits being filed by entities such as Texas Mutual demanding that hospitals reach into their limited budgets to refund stop-loss payments previously received.

SUMMARY OF THE ARGUMENT

Before the Court could deny review in good conscience, it should be able to answer the following straightforward question — the same one that will face the *amici* and other hospitals, as well as insurers, in the 1,500 stop-loss disputes already pending below: "After this court of appeals opinion, what is the test to determine if a hospital admission fits into the stop-loss provision?"

The court of appeals reversed but gave no clear answer. Even the Respondents in this Court have given three different interpretations. Zurich says the court of appeals stated a three-element test. Texas Mutual suggests it is now a two-part test, tracking what TDI argued below. And TDI is no longer quite so sure, saying that the test now has "at least two" elements.

The monetary stakes are high — Respondents also agree that the dollars involved are "significant to the Texas workers' compensation system."[2] For the courts and the jurisprudence, a clear rule also matters. There are a dizzying number of unpaid stop-loss claims still pending, and the new refund suits sparked by the court of appeals opinion are just getting underway. TDI calls this the "'lead' stop-loss case," which could guide the remaining claims through the process.[3] But the court of appeals has instead laid the foundation for more litigation over what should have been a calculator-simple formula.

[2] Brief on the Merits of Respondents Texas Mutual Insurance Co., et al., at 14 (Nov. 12, 2009) ("The dollars in controversy remain significant to the Texas workers' compensation system — the estimated $80-85 million at issue is nearly equal to the $93 million in total workers' compensation inpatient payments to hospitals in 2005.").

[3] The Division of Workers' Compensation's Response to Petition for Review, at iv.

The simple answer is the right one. The natural reading of the Fee Guideline is that the stop-loss method works in the straightforward manner that the rule's definition of "stop-loss threshold" promises: for audited charges exceeding $40,000, a hospital is reimbursed those charges less a 25% discount.[4] That simple formula is underscored by an illustrative "example" given in the rule.[5] And its mathematical simplicity is hardly a vice; it is a perfect complement to the simple per diem applied to low-cost admissions. Both of those formulas — the per diem amount and the stop-loss threshold — were derived from a careful study of existing private contracts. The stop-loss measure, in particular, was chosen to "increase hospital reimbursement" and "ensure access to quality health care."[6] Adhering to the simple formula carries out TWCC's intent, keeps the promises made to Texas hospitals, and opens a clear path to resolve the backlog of stop-loss claims.

* * * * *

The Court should grant rehearing and reinstate this simple, easy-to-apply test.

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[4] 28 TEX. ADMIN. CODE §134.401(b)(1)(H) (definition); *id.* §134.401(c)(6)(B) ("Formula").

[5] 28 TEX. ADMIN. CODE §134.401(c)(6)(C) ("Example").

[6] 22 TEX. REG. 6264, 6279 (July 4, 1997) (explaining that the per diem amounts, the $40,000 threshold, and the 75% reimbursement factor were all based on studies of private hospital contracts and that the Commission believes "the stop-loss threshold chosen increases hospital reimbursement and will ensure fair and reasonable rates for hospitals and ensure access to quality health care for injured workers by providing higher reimbursement for very high cost cases, ensuring that hospitals will continue to treat workers' compensation patients") (emphasis added); *accord id.* at 6269, 6290, 6298.

ARGUMENT

I. WHAT IS THE TEST NOW? AFTER THE COURT OF APPEALS' DECISION, NOT EVEN THE RESPONDENTS CAN AGREE.

The stakeholders know little more about the stop-loss test than they did before this appeal. The court of appeals wiped out the test that had been approved by an *en banc* panel of SOAH —but did not announce a clear rule of its own. Nor did it bless TDI's internal "staff report," instead concluding (rightly) that the report lacked the force of law. As a result, even Respondents cannot agree about what test should be applied to the more than 1,500 pending stop-loss claims — or the new refund lawsuits they are bringing.

A. Are there two elements or three? (The right answer is "one.")

Respondents cannot even agree how many distinct elements are in the test. The three merits briefs each suggest a different answer:

- Texas Mutual frames this as a two-element test about whether "charges exceeded $40,000 and unusually costly or unusually extensive services were required."[7]
- Zurich, by contrast, says that there are three distinct elements — that separate proof is needed both for "unusually costly" and for "unusually extensive."[8]
- TDI hedges its bets about the relationship of these elements, saying "there are at least two elements of the test for payment under the stop-loss exception."[9]

If the Court denies review, the situation below will be no less confused than before this appeal began — and this case seeking to remove uncertainty will have only prolonged it.

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[7] Brief on the Merits of Respondents Texas Mutual Insurance Co., et al., at 15 (emphasis added); *see also id.* at 20 (saying that "unusually extensive" is an "operative test" for "unusually costly").

[8] Zurich American Insurance Company's Brief on the Merits, at 8-9 ("'Extensive' does not necessarily mean 'costly' and vice versa; so both qualifiers are appropriate.").

[9] Texas Department of Insurance, Division of Workers' Compensation's Brief on the Merits, at 16 (emphasis added).

B. What is the right benchmark for measuring "unusually costly" or "unusually extensive"? (The answer that TWCC chose is "$40,000.")

If the isolated and undefined phrases "unusually costly" or "unusually extensive" will be made an element of proof for every stop-loss claim, then hospitals, insurers, and TDI will have to fight through yet more uncertainty about even basic questions:

- Does "unusually" refer to an overall average (as discussed in the preface to the rule, in explaining the $40,000 threshold) or does it now vary with each diagnosis?

  ⇨ Respondents presume that the benchmark slides with each kind of diagnosis. The court of appeals does not say.

- Are these measured against a hospital's audited charges (the figure used in the stop-loss reimbursement "formula"), or will fee disputes now turn into an inquiry about the nuances of each hospital's internal operating costs?

  ⇨ Respondents defend the court of appeals' holding as letting them second-guess internal costs.[10] The court of appeals does not say.

- Are some complex treatments, by their nature, so "unusually costly" or "unusually extensive" that they can regularly qualify for stop-loss to ensure quality care? Or is the typical liver transplant, for example, only covered by the low per diem?

  ⇨ Respondents contend that only the rare outliers of each kind of disease can qualify for stop-loss, thus penalizing efficiency and medical skill. *See* Part II.B, *infra*. The court of appeals does not say.

The answers to these questions are not in the court of appeals opinion. Nor are the answers controlled by the TWCC Staff Report, which (according to the court of appeals) lacks the force of law. Unless this Court reinstates the simple formula provided by the Fee Guideline, these questions (and more) will entangle the 1,500 pending claims.

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[10] The stop-loss rule compensates based on "audited charges," not internal cost. 28 TEX. ADMIN. CODE §134.401(c)(6)(A)-(C). When TWCC meant internal costs, they said so — just as they did in a different part of this Fee Guideline. *Id.* §134.401(c)(4)(A) (certain listed services "shall be reimbursed at cost to the hospital plus 10%"). When they said costs, it was cost "plus 10%." *Id.* (emphasis added). Stop-loss is for "audited charges" less 25%. *Id.* §134.401(c)(6)(A)(iii). There is no reason to think stop-loss was "cost minus."

II. THE COURT OF APPEALS' INTERPRETATION RESTS ON FAULTY ASSUMPTIONS ABOUT MEDICAL COST CONTROL.

A. The Court of Appeals Mistook the Purpose of Stop-Loss.

The court of appeals says that the $40,000 stop-loss threshold "is also contrary to the legislative mandate in the labor code because it precludes the Division from achieving effective medical cost control." 275 S.W.3d at 550; *see also id.* (calling it "absurd and unreasonable" that, after 10 years of inflation, stop-loss payments have become more common).[11] In the end, the court of appeals calls its own interpretation "more reasonable" because, in its view, it offered a better path to cost control. *Id.* at 551.

Critically, the court of appeals did not look to what TWCC said about these economics contemporaneously with the rule. The extensive commentary for the 1997 Fee Guideline does not frame the stop-loss method as a way to achieve cost control. Quite the contrary, it says that its chosen stop-loss threshold "increases hospital reimbursement" to "ensure access to quality health care for injured workers."[12]

To be sure, cost control was one goal for the fee guideline taken as a whole.[13] The stop-loss method, however, is not primarily a tool for cost control. It is a safety valve that lets hospitals take cases that would be inappropriate for the per diem, thus ensuring the quality of medical care. The agency designed a fee guideline to balance those goals by setting a $40,000 stop-loss threshold.

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[11] The court of appeals said it was absurd that "the Stop-Loss *Exception* has replaced the standard per diem method as the general method of hospital reimbursement." 275 S.W.3d at 550 (emphasis in original). But the rule calls stop-loss a "methodology" — neither rule nor the comments call it an "exception." Nor is it absurd for a method to become more common as economic conditions change.

[12] 22 TEX. REG. 6264, 6279 (July 4, 1997); *accord id.* at 6269, 6298.

[13] TEX. LABOR CODE §413.011(d).

B. Respondents' View of "Unusually Costly" and "Unusually Extensive" Would Actually Reward Waste and Punish Efficiency.

Respondents say that the factors to be considered are "complications, infections, multiple surgeries, length of stay, need for specialized equipment, and available statistical information and guidelines for similar cases."[14] They would test each hospital admission against benchmarks about the average stay for similar diseases. Those are seemingly familiar concepts being borrowed for this context.

But by turning "unusually costly" and "unusually extensive" into gateways to the stop-loss payment, Respondents mix up the carrots and sticks. Here's why: If a hospital had to prove "unusually extensive" in order to get stop-loss payments, it would have incentives to provide more care, not less. Similarly, if it had to prove "unusually costly" to qualify for stop-loss payments, it would have no incentive for internal efficiency.

Respondents note that a fixed stop-loss threshold creates an inflection point around $40,000, where a hospital might receive an outsized benefit as charges move from $39,000 to $41,000. Respondents can, of course, audit charges they find suspicious.

But Respondents' rule would extend a similar distortion of incentives all the way up the cost curve. It would penalize the most honest and efficient hospitals, not just for claims that happen to fall just below the $40,000 stop-threshold set by rule, but for every dollar amount all the way up. Consider:

- If Hospital A makes an initial mistake about diagnosis that leads to an extra surgery, or if its patient gets a staph infection while in the hospital, then under Respondents' notion of "unusually extensive," it can qualify for stop-loss.

[14] Brief on the Merits of Respondents Texas Mutual Insurance Co., et al., at 29-30. In practice, fewer than 15% of the stop-loss claims have been exceptional enough to satisfy these factors. *Id.* at 30.

- But if Hospital B nails the diagnosis and does everything right, keeping the costs at or below an average level for a complex procedure — then, under Respondents' reading, it cannot get a stop-loss reimbursement. Instead, Hospital B can collect only the much lower per diem.[15]

Respondents' reading is hardly the "more reasonable." It may lower their own aggregate payouts after-the-fact, but it imputes to the rule irrational and unfair incentives contrary to its design and to the factors commanded by the Labor Code.

III. THE STOP-LOSS METHOD APPLIES TO CLAIMS EXCEEDING $40,000.

A. The Rule Says "Unusually Costly" and "Unusually Extensive" Are Statements of Purpose. It Does Not Say They Are Elements of Proof.

Respondents' theory can be rejected after answering one question: Are the phrases "unusually costly" and "unusually extensive" meant to be statements of purpose or are they meant to be distinct elements of proof?

The surrounding words provide that answer. Both of those contested phrases are introduced by language signaling past purpose:

> "[this] methodology was established to ensure fair and reasonable compensation for unusually costly services,"[16] and
>
> "This stop-loss threshold is established to ensure compensation for unusually extensive services…."[17]

There is no place in the rule where these phrases are stated as distinct elements. Instead, they refer to the stop-loss threshold "established" by the commission.[18]

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[15] Deepening the losses inflicted on efficient hospitals, those per diems are stuck at 1997 levels.

[16] 28 TEX. ADMIN. CODE §134.401(c)(6).

[17] 28 TEX. ADMIN. CODE §134.401(c)(6)(A)(ii).

[18] The commentary confirms that those factors motivated the $40,000 threshold the agency chose. 22 TEX. REG. 6264, 6279, 6288, 6290 (July 4, 1997)

Still, the Court may wonder why the agency showed so much of its work. One explanation is that it had only recently seen its 1992 Fee Guideline struck down for failure to state a "reasoned justification."[19] For the agency to adopt a belt-and-suspenders approach with the 1997 Fee Guideline should be no surprise.

B. Pulling Words Out of Context Is Not "Plain Language."

Rather than examining words in the context of the statute, the court of appeals extracted a few isolated phrases ("unusually costly," "unusually extensive," "minimum") and then rearranged those terms into a new test stated nowhere in the rule. 275 S.W.3d at 550. That is not a valid mode of plain-language statutory construction.

While the court of appeals recites the canon that every word must be given meaning, it ignores the command to consider those words as part of the clauses and sentences in which they appear.[20] For example, the court of appeals would find that the word "minimum" transformed the entire stop-loss provision from a fixed threshold to a fact-intensive inquiry. 275 S.W.3d at 550. But that word appears only as part of a phrase ("minimum stop-loss threshold") that means simply the point above which stop-loss payments are made. *Textron Lycoming Reciprocating Engine Division v. UAW of America*, 523 U.S. 653, 657 (1998) ("It is not the meaning of 'for' we are seeking here, but the meaning of '[s]uits for violation of contracts.'"); *see also Deal v. United States*, 508 U.S. 129, 132 (1993) ("But of course susceptibility of all of these meanings does not

[19] *Texas Hosp. Ass'n v. Texas Workers' Comp. Comm'n*, 911 S.W.2d 884, 885-88 (Tex. App.—Austin 1995, writ denied).

[20] *City of San Antonio v. City of Boerne*, 111 S.W.3d 22, 29 (Tex. 2003) (citing the canon and noting that "the meaning of particular words in a statute may be ascertained by reference to other words associated with them in the same statute").

render the word "conviction," whenever it is used, ambiguous; all but one of the meanings is ordinarily eliminated by context.").

A related canon is that courts should respect lawmakers' decision to omit words. "[E]very word excluded from a statute must also be presumed to have been excluded for a reason."[21] For that reason, a court should not narrow the scope of a rule "to make it inapplicable under circumstances not mentioned in the statute."[22] The court of appeals should not have carved new limitations into the stop-loss threshold set by the agency.

C. Applying the Rule's Own Definitions Gives the Answer.

The rule is far better drafted than Respondents acknowledge. In particular, the definitions of specific industry terms not only foreclose Respondents' arguments — they point the way to a harmonious reading of the whole rule.

Overlooking those definitions, TDI seizes on the word "threshold," saying that it is a "term connoting that further ground must be crossed before one reaches one's destination."[23] But the Court need not guess based on connotations from common usage; "stop-loss threshold" is, in fact, a defined phrase under the rule. And that definition makes quite explicit that this particular monetary threshold is one "beyond which reimbursement is calculated" using the stop-loss methodology. 28 TEX. ADMIN. CODE §134.401(b)(1)(H) (emphasis added).

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[21] *Cameron v. Terrell & Garrett*, 618 S.W.2d 535, 540 (Tex. 1981). *Accord Fitzgerald v. Advanced Spine Fixation Systems, Inc.*, 996 S.W.2d 864, 867 (Tex. 1999).

[22] *Jefferson County Drainage Dist. No. 6 v. Gary*, 362 S.W.2d 305, 307-08 (Tex. 1962) ("A court may not write special exceptions into a statute so as to make it inapplicable under certain circumstances not mentioned in the statute.").

[23] Texas Department of Insurance, Division of Workers' Compensation's Brief on the Merits, at 11.

There is no uncertainty under the rule's definition of "stop-loss threshold," no extra steps of proof. Crossing the defined stop-loss threshold, with audited charges exceeding $40,000, triggers the stop-loss methodology.

PRAYER

The motion for rehearing should be granted, the court of appeals judgment should be reversed, and the Court should restore the simple stop-loss threshold stated in the rule, adopted by the *en banc* panel of SOAH, and declared by the district court.

Respectfully submitted,

/s/Don Cruse
DON CRUSE
State Bar No. 24040744

LAW OFFICE OF DON CRUSE
1108 Lavaca Street, Suite 110-436
Austin, Texas 78701
[Tel.] (512) 853-9100
[Fax] (512) 870-9002
[Email] don@doncruse.com

COUNSEL FOR AMICI CURIAE
THE METHODIST HOSPITAL; PATIENTS MEDICAL CENTER; DOCTORS HOSPITAL 1997, L.P., D/B/A DOCTORS HOSPITAL TIDWELL; AND COVENANT HEALTH SYSTEM

CERTIFICATE OF SERVICE

I certify that on July 6, 2010, a true and correct copy of this of **Amicus Curiae Brief of the Methodist Hospital; Patients Medical Center; Doctors Hospital 1997, L.P., d/b/a Doctors Hospital Tidwell; and Covenant Health System** was served by U.S. mail on all appellate counsel of record in this proceeding as listed below.

Counsel for Petitioner (Christus)

Douglas W. Alexander
ALEXANDER DUBOSE & TOWNSEND LLP
Bank of America Center
515 Congress Avenue, Suite 2350
Austin, Texas 78701

James G. Gumbert
T. Daniel Hollaway
HOLLAWAY & GUMBERT
3701 Kirby Drive, Suite 1288
Houston, Texas 77098

Counsel for Petitioner (Vista)

David F. Bragg
LAW OFFICES OF DAVID F. BRAGG, P.C.
211 East Seventh Street Suite 920
Austin, Texas 78701

Counsel for Respondent (TDI-DWC)

Nicholas Canaday, III
Assistant Attorney General
Administrative Law Division
P.O. Box 12548, Capitol Station
Austin, Texas 78711-2548

Counsel for Respondent (Zurich)

Steven M. Tipton
FLAHIVE, OGDEN & LATSON
P.O. Box 13367
Austin, Texas 78711

Counsel for Respondent (TMIC)

P.M. Schenkkan
GRAVES, DOUGHERTY, HEARON & MOODY, P.C.
P.O. Box 98
Austin, Texas 78767-0098

Mary Barrow Nichols
TEXAS MUTUAL INSURANCE CO.
6210 E. Hwy. 290
Austin, Texas 78723

Dudley D. McCalla
HEATH, DAVIS & MCCALLA, P.C.
720 Brazos Street, Suite 200
Austin, Texas 78701

Daniel Pozza
LAW OFFICE OF DAN POZZA
239 E. Commerce Street
San Antonio, Texas 78205

Counsel for Respondent (Zenith)

J. Stephen Ravel
KELLY HART & HALLMAN, LLP
301 Congress Ave., Suite 2000
Austin, Texas 78701

James M. Loughlin
STONE LOUGHLIN & SWANSON LLP
P.O. Box 30111
Austin, Texas 78755

Counsel for Amicus
Insurance Council of Texas

John D. Pringle
JOHN D. PRINGLE, P.C.
The Vaughn Building
807 Brazos, Suite 200
Austin, Texas 78701

Counsel for Respondent
(Liberty Mutual)

Robert F. Josey
Catherine L. Hanna
HANNA & PLAUT, LLP
The Littlefield Building
106 East Sixth Street, Suite 600
Austin, Texas 78701

Counsel for Amicus Curiae
Texas Hospital Association

Pamela Stanton Baron
Post Office Box 5573
Austin, Texas 78763

/s/Don Cruse
Don Cruse

22 TEX. REG.
(excerpts)

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

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

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

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

♦ ♦ ♦

Part XXIII. Texas Real Estate Commission

Chapter 535. Provisions of the Real Estate License Act

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

22 TAC §535.61

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

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

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

§535.61. Examinations and Acceptance of Courses.

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

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

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

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

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

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

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

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

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Mark A. Moseley
General Counsel
Texas Real Estate Commission
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For further information, please call: (512) 465–3900

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TITLE 28. INSURANCE

Part II. Texas Workers' Compensation Commission

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

Subchapter E. Health Facility Fees

28 TAC §134.400

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The cost calculation on which cost-based models are derived, uses hospital charges as its basis. Each hospital determines its own charges. The hospital charge data in the Commission's database, as with all hospital charge data, shows that it is well above the actual fees paid for most hospital services. A study by Commission staff indicated that charges for surgical hospital admissions (per TWCC billing database) increased by 107.0% from 1992 to 1996 and by 65% from 1993 through 1996, whereas for those same periods of time the Consumer Price Index (CPI) reflected an inflation rate of 16% and 12% respectively, and the Medical Care Services group of the CPI reflected an inflation rate of 29% and 18% respectively. For these reasons, hospital charges are not a valid indicator of a hospitalþs costs of providing services nor of what is being paid by other payors. Therefore, under a so-called cost based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory mandate of achieving effective medical cost control and the mandate not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Susan Cory
General Counsel
Texas Workers' Compensation Commission
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For further information, please call: (512) 440–3700

28 TAC §134.401

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

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

§134.401. Acute Care Inpatient Hospital Fee Guideline.

(a) Applicability.

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

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

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

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

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

(b) General Ground Rules.

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

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

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

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

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

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

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

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

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

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

(J) Standard Per Diem Amount (SPDA) - A standardized per diem amount established by the Commission as the maximum reimbursement for hospital services covered by this guideline.

(2) General Information.

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

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

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

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

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

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

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

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

(c) Reimbursement.

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

(2) Method. All inpatient services provided by an acute care hospital for medical and/or surgical admissions will be reimbursed using a service related standard per diem amount.

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

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

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

(3) Reimbursement Calculation.

(A) Explanation.

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

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

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

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

(B) Formula. LOS x SPDA = WCRA

(C) Examples.

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

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

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

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

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

(ii) Orthotics and prosthetics (revenue code 274)

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

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

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

(iii) Hyperbaric oxygen (revenue code 413);

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

(v) Air ambulance (revenue code 545).

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

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

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

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

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

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

(A) Explanation.

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

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

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

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

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

(B) Formula. Audited Charges x SLRF = WCRA

(C) Example.

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

(7) Reimbursement for Other Services.

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

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

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

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

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

♦ ♦ ♦

TITLE 31. NATURAL RESOURCES AND CONSERVATION

Part II. Texas Parks and Wildlife Department

Chapter 65. Wildlife

Subchapter A. Statewide Hunting and Fishing Proclamation

General Provisions

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

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

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

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

COA Opinion

TEXAS MUTUAL INSURANCE COMPANY, Liberty Mutual Insurance Company, Zenith Insurance Company and Zurich American Insurance Company, Appellants,

v.

VISTA COMMUNITY MEDICAL CENTER, LLP, d/b/a Vista Medical Center Hospital; Christus Health Gulf Coast; and The Texas Department of Insurance, Division of Workers' Compensation, Appellees.

No. 03–07–00682–CV.

Court of Appeals of Texas, Austin.

Nov. 13, 2008.

Rehearing Overruled Jan. 13, 2009.

Background: Hospital filed action appealing decision of medical dispute resolution officer (MDRO), in which it challenged interpretation of rule promulgated by the Department of Insurance, Division of Workers' Compensation (Division) regarding stop-loss exception to standard per diem methodology for inpatient hospital services to workers' compensation claimants. Workers' compensation insurer filed a counterclaim against hospital and a cross-claim against Division challenging the validity of the rule. Another hospital and other workers' compensation insurers intervened. Following a bench trial, the District Court of Travis County, 353rd Judicial District, Margaret A. Cooper, J., entered judgment for hospitals. Division and insurers appealed.

Holdings: The Court of Appeals, Jan P. Patterson, J., held that:

(1) stop-loss exemption rule required hospitals to demonstrate that the admission involved unusually costly and unusually extensive services, in addition to demonstrating that charges exceeded $40,000;

(2) failure of Division to review stop-loss rule exemption every two years and to provide fee reimbursement guidelines that followed Medicare methodologies did not invalidate rule;

(3) terms "unusually costly" and "unusually extensive" in stop-loss rule were not so vague and uncertain that their use in determining whether the exception applied would be arbitrary;

(4) Division staff report interpreting stop-loss rule was not a rule that had to be adopted in conformance with Administrative Procedures Act (APA) procedures; and

(5) stop-loss rule did not allow workers' compensation carriers to audit a health care provider's charges for implantables, orthotics, and prosthetics to cost plus 10% when determining whether the $40,000 stop-loss threshold had been met.

Affirmed in part, and reversed in and rendered part.

1. Declaratory Judgment ⚿393

A trial court's declaratory judgment is reviewed de novo.

2. Administrative Law and Procedure ⚿391

When considering a challenge to the validity of an administrative rule, courts begin with the presumption that the rule is valid, and the party challenging the rule has the burden of demonstrating its invalidity.

3. Administrative Law and Procedure ⚿412.1

Courts construe administrative rules, which have the same force and effect as statutes, in the same manner as statutes.

4. Workers' Compensation ⚿1094

In construing a rule issued by the Department of Insurance, Division of Workers' Compensation (Division), a court's primary objective is to give effect to the Division's intent.

5. Workers' Compensation ⚿1094

Courts defer to the an interpretation by the Department of Insurance, Division of Workers' Compensation (Division) of its own rules so long as that interpretation is reasonable and consistent with the plain language of the rule. V.T.C.A., Government Code § 311.023(6).

6. Administrative Law and Procedure ⚿413

In an appeal of an agency interpretation of its own rule, court review is limited to determining whether the administrative interpretation is plainly erroneous or inconsistent with the rule.

7. Administrative Law and Procedure ⚿413

If an agency fails to follow the clear, unambiguous language of its own regulation, a court must reverse its action as arbitrary and capricious.

8. Administrative Law and Procedure ⚿412.1

When construing an administrative rule, courts must read the rule as a whole, giving meaning and purpose to every part.

9. Administrative Law and Procedure ⚿412.1

Courts should not construe an administrative rule in a way that would lead to an absurd or unreasonable result if anoth-

er more reasonable construction or interpretation exists.

10. Administrative Law and Procedure ⚿412.1

When construing an administrative rule, courts give effect to all words in the rule and, if possible, do not treat any words as mere surplusage.

11. Administrative Law and Procedure ⚿412.1

Courts avoid construing administrative rules in a way that would render portions of the rule inoperable or meaningless.

12. Workers' Compensation ⚿991.5

Stop-loss exception rule adopted by Department of Insurance, Division of Workers' Compensation (Division), providing stop-loss exception to standard per diem methodology for inpatient hospital services to workers' compensation claimants, required hospitals to demonstrate more than that charges exceeded $40,000, and in addition required hospitals to demonstrate that the admission involved unusually costly and unusually extensive services; rule stated exception was established to ensure compensation for unusually costly and unusually extensive services during a hospital admission, that $40,000 was the minimum threshold and that the exception was to be allowed on a case-by-case basis, and an interpretation allowing exception to apply merely because charges exceeded $40,000 would be contrary to mandate in Labor Code that Division achieve effective medical cost control. V.T.C.A., Labor Code § 413.011; 28 TAC § 134.401(c)(6) (Repealed).

13. Administrative Law and Procedure ⚿390.1

The measure of the validity of an agency rule is whether it is constitutional and whether it conforms to the procedural and substantive statutes applicable to its adoption.

14. Workers' Compensation ⚿1092

Failure of Department of Insurance, Division of Workers' Compensation (Division) to review and revise stop-loss rule exception to standard per diem methodology for inpatient hospital services to workers' compensation claimants every two years and provide fee guidelines that followed Medicare reimbursement methodologies, as required by provisions in Labor Code, did not invalidate the rule, though Labor Code provisions used the word "shall," as the legislature did not provide for any consequences for Division's noncompliance with the directives. V.T.C.A., Labor Code §§ 413.011, 413.012; 28 TAC § 134.401(c)(6) (Repealed).

15. Statutes ⚿227

To determine whether the legislature intended a provision to be mandatory or directory, courts consider the plain meaning of the words used, as well as the entire act, its nature and object, and the consequences that would follow from each construction.

16. Statutes ⚿184

When a statute is silent about consequences of noncompliance, courts look to the statute's purpose in determining the proper consequence of noncompliance.

17. Time ⚿2

If a statute requires that an act be performed within a certain time without any words restraining the act's performance after that time, the timing provision is usually directory.

18. Workers' Compensation ⚿51

Courts liberally construe workers' compensation legislation to carry out its evident purpose of compensating injured workers and their dependents.

19. Workers' Compensation ⚿991.5

Fee guidelines for health care providers providing treatment to workers' compensation claimants are just that, guidelines, and merely assist carriers and, upon review, the Department of Insurance, Division of Workers' Compensation (Division) in determining whether medical charges are fair and reasonable or satisfy the applicable standard.

20. Workers' Compensation ⚿991.5

There is no private right to an updated fee guideline or a guideline that uses a particular reimbursement methodology, for purposes of health care provider fees to care for workers' compensation claimants, so long as the reimbursement provided in the guideline is fair and reasonable.

21. Workers' Compensation ⚿991.5

Terms "unusually costly" and "unusually extensive," in rule adopted by Department of Insurance, Division of Workers' Compensation (Division) establishing stop-loss exception to standard per diem methodology for inpatient hospital services to workers' compensation claimants, were not so vague and uncertain that their use in determining whether the exception applied would be arbitrary; terms only recognized that what was "unusually costly" and "unusually expensive" in a particular fee dispute was a fact-intensive inquiry best left to the Division's determination on a case-by-case basis. 28 TAC § 134.401(c)(6) (Repealed).

22. Administrative Law and Procedure ⚿390.1

Statutes ⚿47

There is no constitutional requirement that a statute or rule must define all of the terms used.

23. Administrative Law and Procedure ⚿390.1

Recognizing the myriad of factual situations that may arise and allowing administrative agencies sufficient flexibility when drafting their rules, courts require no more than a reasonable degree of certainty defining what is required or prohibited.

24. Administrative Law and Procedure ⚿390.1

Courts will invalidate an economic regulation only if it commands compliance in terms so vague and indefinite as really to be no rule or standard at all or if it is substantially incomprehensible.

25. Workers' Compensation ⚿1092

Staff report issued by Department of Insurance, Division of Workers' Compensation (Division), regarding interpretation of Division rule establishing stop-loss exception to standard per diem methodology for inpatient hospital services to workers' compensation claimants, was not a rule within the meaning of the Administrative Procedures Act (APA) that had to be adopted in compliance with the APA; report was a one-page document prepared to address inconsistent applications of the stop-loss rule by Division's medical dispute resolution officers (MDROs), and only proposed a correction to the internal inconsistency based on the language of the rule. V.T.C.A., Government Code §§ 2001.003(6), 2001.0225 to 2001.034; 28 TAC § 134.401(c)(6) (Repealed).

26. Administrative Law and Procedure ⚿382.1

Not every administrative pronouncement is a rule within the meaning of the Administrative Procedures Act (APA); administrative agencies routinely issue letters, guidelines, and reports, and occasionally file briefs in court proceedings, any of which might contain statements that intrinsically implement, interpret, or pre-

scribe law, policy, or procedure or practice requirements, and if such statements were rules, an agency could not carry out its legislative functions. V.T.C.A., Government Code §§ 2001.003(6), 2001.0225 to 2001.034.

27. Workers' Compensation ⇨1094

The Department of Insurance, Division of Workers' Compensation (Division) has authority to interpret its own rules.

28. Workers' Compensation ⇨991.5

Rule adopted by Department of Insurance, Division of Workers' Compensation (Division), establishing stop-loss exception to standard per diem methodology for inpatient hospital services to workers' compensation claimants, did not allow workers' compensation carriers to audit a health care provider's charges for implantables, orthotics, and prosthetics to cost plus 10% when determining whether the $40,000 stop-loss threshold had been met. 28 TAC § 134.401(c)(6) (Repealed).

Thomas B. Hudson Jr., Robin A. Melvin, Christopher H. Trickey, P. M. Schenkkan, Graves, Dougherty, Hearon & Moody, P.C., Steven M. Tipton, Flahive, Ogden & Latson, P.C., Nicholas Canaday, III, Office of the Atty. Gen., Dudley D. McCalla, Heath, Davis & McCalla, P.C., Mary Barrow Nichols, Mary Barrow Nichols, Gen. Counsel, Austin, for Appellants.

David F. Bragg, Law Office of David F. Bragg, P.C., Eric G. Carter, The Carter Law Firm, Austin, for Appellees.

Before Justices PATTERSON, WALDROP and HENSON.

OPINION

JAN P. PATTERSON, Justice.

This appeal concerns a challenge to the validity of a rule promulgated by the Texas Department of Insurance, Division of Workers' Compensation,[1] regarding hospital fee reimbursement for inpatient services to injured workers' compensation patients. *See* 22 Tex. Reg. 6264–308 (July 4, 1997) (originally codified at 28 Tex. Admin. Code § 134.401), *repealed*, 33 Tex. Reg. 5319 (July 4, 2008). Appellee Vista Community Medical Center, LLP, d/b/a Vista Medical Center Hospital filed suit against the Division and appellant Texas Mutual Insurance Company in a medical fee reimbursement dispute seeking a declaratory judgment that the "Stop–Loss Exception" in Rule 134.401[2] was invalid. Another hospital, appellee Christus Health Gulf Coast, and several insurance carriers, including appellants Liberty Mutual Insurance Company, Zenith Insurance Company, and Zurich American Insurance Company, intervened and sought competing declarations regarding the validity of Rule

1. The rule at issue was originally promulgated by the Texas Workers' Compensation Commission in 1997, but the legislature abolished the TWCC in 2005 and transferred its duties and rules to the Division of Workers' Compensation within the Texas Department of Insurance. *See* Act of May 29, 2005, 79th Leg., R.S., ch. 265, §§ 8.001(b), .004(a), 2005 Tex. Gen. Laws 468, 607–11. In light of this change, we refer to the agency throughout this opinion as either the "Commission" or the "Division."

2. Rule 134.401 was adopted in 1997, *see* 22 Tex. Reg. 6264 (July 4, 1997), and formerly codified at 28 Tex. Admin. Code § 134.401 (2007), but has since been repealed. *See* 33 Tex. Reg. 5319 (July 4, 2008) (repealing Rule 134.401). Because the 1997 rule remains in effect for admissions occurring prior to its repeal effective March 1, 2008, we refer to the rule as "Rule 134.401" or the "1997 guideline."

134.401. The trial court severed the parties' claims for declaratory relief and, after a bench trial, issued a final judgment granting declaratory relief in favor of the hospitals and rejecting the Division's interpretation of the Stop–Loss Exception. Because we conclude there was error in the trial court's judgment, we affirm the trial court's judgment in part, and reverse and render in part.

FACTUAL AND PROCEDURAL BACKGROUND

In 1989, the Texas Legislature enacted a new Workers' Compensation Act that restructured workers' compensation law in Texas. *See* Tex. Lab.Code Ann. §§ 401.001–506.002 (West 2006 & Supp. 2008).[3] The Act charged the Division with the difficult task of developing medical fee reimbursement guidelines that would ensure quality medical care for injured workers and achieve effective medical cost control. *Id.* § 413.011; *see also Patient Advocates v. Texas Workers' Comp. Comm'n*, 80 S.W.3d 66, 71 (Tex.App.-Austin 2002), *aff'd in part, rev'd in part*, 136 S.W.3d 643 (Tex.2004). To satisfy its legislative mandate to balance these competing legislative policy goals, the Division adopted the 1992 hospital reimbursement guideline, which was invalidated by this Court in 1995 for lack of a reasoned justification. *See Texas Hosp. Ass'n v. Texas Workers' Comp. Comm'n*, 911 S.W.2d 884, 885–86, 888 (Tex.App.-Austin 1995, writ denied) (declaring "Rule 400" void because it failed to include reasoned justification as required by section 2001.033 of the APA). In the wake of this Court's decision, the Division adopted the 1997 guideline, including the Stop–Loss Exception, at issue in this appeal. *See* 22 Tex. Reg. 6264.

The 1997 Guideline

With certain exceptions, the 1997 guideline provides that hospitals are to be reimbursed for inpatient admissions under a standard per diem methodology based on the category of admission. *See generally* Rule 134.401(c)(1)-(2). The 1997 guideline also specifies two exceptions to the standard per diem reimbursement methodology. *Id.* 134.401(c)(2)(C). These two exceptions apply on a case-by-case basis and include the "Trauma–Burn–HIV," or "TBHIV," exception, and the Stop–Loss Exception. *See id.* 134.401(c)(5) & (6). Only the Stop–Loss Exception is at issue in this appeal.

With regard to the Stop–Loss Exception, Rule 134.401(c)(6) provides:

> Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. This methodology shall be used in place of and not in addition to the per diem based reimbursement system. The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.
>
> (A) Explanation
>
> (i) To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold.
>
> (ii) This stop-loss threshold is established to insure compensation for unusually extensive services required during an admission.

3. The Workers' Compensation Act was initially located in articles 8303–1.01 through 8308–11.10 of the Texas Revised Civil Statutes, but was codified in the labor code in 1993. *See* Act of May 12, 1993, 73rd Leg., R.S., ch. 269, 2003 Tex. Gen. Laws 987.

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

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

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

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

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

Rule 134.401(c)(6). In addition, Rule 134.401 also defines the terms "Stop–Loss Payment," "Stop–Loss Reimbursement Factor," and "Stop–Loss Threshold." *Id.* § 134.401(b)(1)(F)-(H). Stop–Loss Payment is "[a]n independent method of payment for an unusually costly or lengthy stay." *Id.* § 134.401(b)(1)(F). Stop–Loss Reimbursement Factor is "[a] factor established by the Commission to be used as a multiplier to establish a reimbursement amount when the total hospital charges have exceeded specific stop-loss thresholds." *Id.* § 134.401(b)(1)(G). Stop–Loss Threshold is "[the] Threshold of total charges established by the Commission, beyond which reimbursement is calculated by multiplying the applicable Stop–Loss Reimbursement Factor by the total charges identifying that particular threshold." *Id.* § 134.401(b)(1)(H).

Rule 134.401 also sets forth certain general information as follows: All hospitals must bill their "usual and customary charges." *Id.* § 134.401(b)(2)(A). Hospital reimbursement for acute care hospital inpatient services rendered shall be the lesser of pre-negotiated rates between the hospital and insurance carrier, the hospital's usual and customary charges, or reimbursement as set out in subsection (c) of Rule 134.401 for the particular admission. *Id.* § 134.401(b)(2)(A)(i)-(iii). Additional Reimbursements as outlined in subsection (c)(4) will be determined on a case-by-case basis within the guidelines established for the specific services rendered. *Id.* § 134.401(b)(2)(B). Finally, all hospital charges are subject to audit as described in the Commission's rules. *Id.* § 134.401(b)(2)(C).

Medical Fee Disputes

In 2001, with health care costs rising, the Division began to see a corresponding rise in the number of medical fee disputes between hospitals and insurance carriers. Under the labor code, a health care provider dissatisfied with a carrier's payment can file an administrative dispute with the Division. *See* Tex. Lab.Code Ann. § 413.031(a) (West Supp.2008). A Division employee known as a medical dispute resolution officer, or MDRO, reviews the complaint and documentation filed by the provider and the carrier and determines the appropriate reimbursement due the provider under the labor code and the Division's rules. *See id.* § 413.031(c); 28 Tex. Admin. Code § 133.307 (2007). If either party is dissatisfied with the MDRO's deci-

sion, that party can request a hearing before an Administrative Law Judge at the State Office of Administrative Hearings (SOAH). *See* Tex. Lab.Code Ann. § 413.031(k).[4] Under the labor code, the ALJ issues the final administrative order. *See id.* §§ 402.073(b) (West Supp.2008), 413.031(k). But a party may seek judicial review of the ALJ's order in a Travis County District Court under the substantial evidence rule. *See id.* § 413.031(k–1).

Many of these administrative fee disputes concerned the applicability of the Stop–Loss Exception. The hospitals argued that the Stop–Loss Exception applied whenever the audited charges for a particular admission exceeded $40,000. The hospitals thus urged that whenever the audited charges for a particular admission exceeded $40,000, reimbursement should be paid at 75% of the total audited charges using the Stop–Loss Reimbursement Factor in Rule 134.401. *See* Rule 134.401(c)(6)(A)(iii). The insurance carriers disagreed and argued that reimbursing a hospital admission at 75% of the total audited charges anytime those charges exceeded $40,000 would produce a windfall for the hospitals and defeat the statutory objective of achieving effective medical cost control. Accordingly, the carriers urged that, in addition to total audited charges exceeding $40,000, a hospital must prove that an admission involved "unusually costly" and "unusually extensive" services, before the Stop–Loss Exception applied. Essentially, the carriers argued that the hospitals must satisfy a two-pronged test before reimbursement under the Stop–Loss Exception applied.

When resolving these initial administrative disputes, the Division's MDROs issued conflicting opinions regarding the applicability of the Stop–Loss Exception. Some MDROs applied the Stop–Loss Exception whenever total audited charges exceeded $40,000, and some MDROs applied the Stop–Loss Exception on a case-by-case basis only to those cases involving unusually costly and unusually extensive services where total audited charges exceeded $40,000. For those cases appealed to SOAH, the first SOAH decisions issued in 2001 applied the Stop–Loss Exception on a case-by-case basis only to those cases involving unusually costly and unusually extensive services in which total audited charges exceeded $40,000. Thereafter, SOAH ALJs issued conflicting decisions on when to apply the Stop–Loss Exception. Like the Division's MDROs, some ALJs applied the Stop–Loss Exception whenever total audited charges exceeded $40,000, and other ALJs applied the Stop–Loss Exception on a case-by-case basis only in those cases involving unusually costly or unusually extensive services where total audited charges exceeded $40,000.

The 2005 Staff Report & Resulting Appeals

When Allen McDonald became Director of the Medical Review Division in 2004, he identified an internal split among Division employees over the proper interpretation and application of the Stop–Loss Exception. In the fall of 2004, McDonald or-

4. There was a window of time between 2005 and 2007 when a party was not entitled to request a hearing at SOAH. In 2005, the Legislature amended section 413.031(k) to eliminate the option of requesting a hearing at SOAH in a medical fee dispute. *See* Act of May 29, 2005, 79th Leg., R.S., ch. 265, § 3.245, 2005 Tex. Gen. Laws 469, 554 (amending section 413.031(k) of the labor code). But, in 2007, the Legislature re-wrote section 413.031(k) again and restored the option of requesting a SOAH hearing before seeking judicial review in a medical fee dispute. *See* Act of May 23, 2007, 80th Leg., R.S., ch. 1007, § 1, 2007 Tex. Gen. Laws 3525, 3525 (codified at Tex. Lab.Code Ann. § 413.031(k) (West Supp.2008)).

dered a halt in the issuance of MDRO decisions in Stop–Loss Exception disputes until he could investigate further. At the January 2005 public meeting, the Division's Chairman inquired about the inconsistent agency positions regarding the Stop–Loss Exception. McDonald promised to report back at the next meeting. At the February 2005 public meeting, McDonald presented the 2005 Staff Report, a one-page document in which McDonald explained the proper interpretation and application of the Stop–Loss Exception. The 2005 Staff Report explained that in order to qualify for Stop–Loss Payment, an admission must have audited charges exceeding $40,000 and the admission must involve unusually costly and unusually extensive services. The agency Commissioners acknowledged McDonald for his presentation but took no official action regarding the 2005 Staff Report.

Between February 2005 and June 2006, Division MDROs applied the two-part interpretation of the Stop–Loss Exception in the 2005 Staff Report in almost 1,500 disputes. Many of these disputes, including the dispute that led to this case, were appealed directly to the district court.[5]

The 2007 En Banc Panel Decision

After the Staff Report was issued in 2005, SOAH began consolidating the Stop–Loss Exception disputes into one docket for consideration of threshold legal issues. This docket was assigned to an en banc panel of nine SOAH ALJs in 2006. In January 2007, after briefing on a limited record, the en banc panel rejected the Division's interpretation and application of the Stop–Loss Exception as explained in the 2005 Staff Report and held, 7–2, that the Stop–Loss Exception applied in any case in which total audited charges exceeded $40,000. The en banc panel held that this dollar amount threshold was the only prerequisite for payment under the stop-loss method. In addition, the en banc panel held that a hospital's implant charges, regardless of mark-up, must be used when deciding whether the $40,000 threshold has been met. The en banc panel rejected the carriers' arguments that implant charges should be reduced to cost plus 10% as required in Rule 134.401 when determining whether audited charges exceeded $40,000.

Since the issuance of the en banc panel decision, SOAH ALJ's have ordered numerous reimbursements at 75% of audited charges. Most carriers have paid under protest and perfected appeals to the district court in these cases.[6]

The Trial Court's Judgment

The instant appeal originated in 2006 when Vista appealed one of the many decisions rendered by the Division's MDROs pursuant to the 2005 Staff Report. In addition to the suit for judicial review allowed under the labor code, Vista sought a declaration under section 2001.038 of the Administrative Procedure Act, *see* Tex. Gov't Code Ann. § 2001.038 (West 2000), regarding the proper interpretation of the Stop–Loss Exception, as well as a declaration that the 2005 Staff Report was an invalidly adopted rule.

As one of the defendants in Vista's lawsuit, Texas Mutual filed an answer and counterclaim against Vista, as well as a cross-claim against the Division challeng-

5. These appeals were taken during the window of time when parties were not entitled to a hearing at SOAH. *See* note 4 *supra*. The parties have informed the Court that these appeals are inactive pending resolution of this appeal.

6. The parties agree that these appeals are likewise inactive pending resolution of this appeal.

ing the validity of Rule 134.401 and the Stop–Loss Exception. Texas Mutual sought competing declarations that the 1997 guideline, properly interpreted: (1) required that charges for implants be audited to cost plus 10% before determining whether an admission met the $40,000 minimum stop-loss threshold; and (2) required a hospital to prove that the services provided in an admission were unusually costly and unusually extensive before that admission was entitled to Stop–Loss Payment under Rule 134.401. Alternatively, Texas Mutual sought a declaration that the Stop–Loss Exception was invalid because it violated statutory standards and was an unconstitutional delegation of the Division's legislative authority to private parties.

Several carriers and another hospital intervened and sought declaratory relief regarding the application and validity of the Stop–Loss Exception. The trial court severed the parties' claims for declaratory relief from Vista's administrative appeal. After a bench trial, the trial court entered final judgment with the following declarations:

1. The Court declares that the stop-loss reimbursement methodology of the Acute Care Inpatient Hospital Fee Guideline found at 28 Texas Administrative Code § 134.401(c)(6) requires only that a provider prove that its total audited charges exceed $40,000 in order for the stop-loss reimbursement methodology to apply; there is no additional requirement that a provider prove that the admission was unusually costly, or unusually extensive[,] in order for the stop-loss reimbursement methodology to apply.
2. The Court declares that the Staff Report that was admitted into evidence as Vista Exhibit 9 and Joint Exhibit 4 is an administrative rule as defined in Tex. Gov't Code § 2001.003(6) and is invalid and voidable because it was not adopted in substantial compliance with Tex. Gov't Code § 2001.0225 through Tex. Gov't Code § 2001.034.
3. Instead of remanding the rule to the Division under Tex. Gov't Code § 2001.040 to allow a reasonable time for the Division to either revise or readopt the rule through established procedures, the Court finds good cause to immediately invalidate the Staff Report because the Court holds that absent the addition of objective criteria, the phrases "unusually costly" and "unusually extensive" as used by the Division are so vague and uncertain that their use in determining whether the stop-loss reimbursement methodology applies would be arbitrary.
4. The Court declares that when determining whether payment is due under 28 Tex. Admin. Code 134.401(c)(6), a carrier is authorized to audit all hospital charges in accordance with applicable Division retrospective rules, and is not limited to auditing for the deductions as described in 28 Tex. Admin. Code § 134.401(c)(6)(A)(v).
5. The Court declares that under 28 Tex. Admin. Code § 134.401(c)(6), a carrier is not authorized to reduce the provider's usual and customary charges for implantables, orthotics and prosthetics to cost plus 10% in determining whether the stop-loss reimbursement methodology applies for reimbursement purposes.

The trial court's judgment denied all further relief not specifically granted and ordered that each party was to bear its own costs, attorney's fees, and other expenses.

The trial court denied Texas Mutual's motion for new trial, and the insurance carriers, including Texas Mutual, Liberty Mutual, Zenith, and Zurich American, appealed to this Court. The Division did not appeal.

DISCUSSION

This appeal involves the proper interpretation and application of Rule 134.401. The carriers urge reversal of the trial court's judgment arguing that the trial court's declarations erroneously interpret Rule 134.401. The hospitals counter that the trial court's judgment was proper and this Court should affirm. The Division does not appeal the trial court's judgment but urges this Court to reject the carriers' challenges to the validity of Rule 134.401. For the reasons discussed below, we determine the trial court erred in its interpretation of Rule 134.401.

Standard of Review

[1] We review the trial court's declaratory judgment *de novo*. *See City of San Antonio v. City of Boerne,* 111 S.W.3d 22, 25–26 (Tex.2003).

[2–7] This appeal concerns a challenge to the validity of an administrative rule under section 2001.038 of the government code. *See* Tex. Gov't Code Ann. § 2001.038. When considering a challenge to the validity of an administrative rule, we begin with the presumption that the rule is valid, and the party challenging the rule has the burden of demonstrating its invalidity. *See Office of Pub. Util. Counsel v. Public Util. Comm'n,* 104 S.W.3d 225, 232 (Tex.App.-Austin 2003, no pet.); *McCarty v. Texas Parks & Wildlife Dep't,* 919 S.W.2d 853, 854 (Tex.App.-Austin 1996, no writ) (citing cases). We construe administrative rules, which have the same force and effect as statutes, in the same manner as statutes. *Rodriguez v. Service Lloyds Ins. Co.,* 997 S.W.2d 248, 254 (Tex.1999); *Lewis v. Jacksonville Bldg. & Loan Ass'n,* 540 S.W.2d 307, 310 (Tex.1976). In construing a Division rule, our primary objective is to give effect to the Division's intent. *Rodriguez,* 997 S.W.2d at 254. We defer to the Division's interpretation of its own rules so long as that interpretation is reasonable and consistent with the plain language of the rule. *Public Util. Comm'n v. Gulf States Utils. Co.,* 809 S.W.2d 201, 207 (Tex.1991); *see also* Tex. Gov't Code Ann. § 311.023(6) (West 2005). Our review is limited to determining whether the administrative interpretation is plainly erroneous or inconsistent with the rule. *Gulf States Utils.,* 809 S.W.2d at 207 (citing *United States v. Larionoff,* 431 U.S. 864, 872, 97 S.Ct. 2150, 53 L.Ed.2d 48 (1977)). However, if an agency fails to follow the clear, unambiguous language of its own regulation, we must reverse its action as arbitrary and capricious. *Id.* (citing *Sam Houston Elec. Coop., Inc. v. Public Util. Comm'n,* 733 S.W.2d 905, 913 (Tex.App.-Austin 1987, writ denied)).

Carrier Claims

On appeal, the insurance carriers raise several challenges to the trial court's judgment. In general, the carriers argue that the trial court erred in its construction of Rule 134.401 and in its declaration that Rule 134.401 was a valid rule.[7] The carriers argue that Rule 134.401 is valid if properly interpreted. The carriers assert that the proper interpretation of Rule 134.401 requires proof that audited charges exceed $40,000, as well as proof that an admission involved unusually costly and unusually extensive services, before an admission can be paid under the Stop–

7. Certain carriers argue that Rule 134.401 has been invalid since its inception or that it has become invalid for the various reasons we discuss.

Loss Exception. The carriers also argue that the trial court erred in its declaration that the terms "unusually costly" and "unusually extensive" are so vague as to be arbitrary and that the trial court should not have found the 2005 Staff Report to be an invalid rule. Finally, the carriers argue that the trial court erred in its declaration that the charges for implantables, orthotics, and prosthetics could not be audited to cost plus 10% when determining whether audited charges exceed $40,000.

Alternatively, the carriers assert that Rule 134.401 as interpreted by the trial court is invalid because it fails to satisfy the statutory requirements of labor code section 413.011. In particular, the carriers argue that Rule 134.401 as interpreted by the trial court violates labor code section 413.011 because:

- it does not result in fair and reasonable reimbursement;
- it is not based on Medicare reimbursement policies and methodologies;
- it has not been reviewed and revised every two years;
- it no longer achieves effective medical cost control;
- it constitutes an unconstitutional private delegation of agency authority;
- it allows for reimbursement for medical services in excess of those amounts charged for similar treatment to individuals with an equivalent standard of living; and
- it is inconsistent with the labor code definition of "medical benefit."

1. Interpretation of the Stop–Loss Exception

We begin our analysis of the carriers' claims with a review of the trial court's interpretation of Rule 134.401. The carriers challenge the trial court's interpretation of the Stop–Loss Exception, or section 134.401(c)(6) of the rule. The plain language of the rule provides that the stop-loss method is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. *See* Rule 134.401(c)(6). The rule also provides that the stop-loss threshold was established to ensure compensation for unusually extensive services during a hospital admission and that an admission is eligible for stop-loss payment if the total audited charges exceed $40,000. *Id.* § 134.401(c)(6)(A)(i)-(ii).

[8–11] We construe administrative rules, which have the same force as statutes, in the same manner as statutes. *Rodriguez,* 997 S.W.2d at 254. As when construing a statute, we must read the rule as a whole, giving meaning and purpose to every part. *See Sharp v. House of Lloyd, Inc.,* 815 S.W.2d 245, 249 (Tex.1991); *Ex Parte Pruitt,* 551 S.W.2d 706, 709 (Tex. 1977). We should not construe a rule in a way that would lead to an absurd or unreasonable result if another more reasonable construction or interpretation exists. *See National Plan Adm'rs, Inc. v. National Health Ins. Co.,* 235 S.W.3d 695, 701 (Tex. 2007); *C & H Nationwide v. Thompson,* 903 S.W.2d 315, 322 n. 5 (Tex.1994). We give effect to all words in the rule and, if possible, do not treat any words as mere surplusage. *See Spradlin v. Jim Walter Homes, Inc.,* 34 S.W.3d 578, 580 (Tex. 2000). Accordingly, we avoid construing rules in a way that would render portions of the rule inoperable or meaningless. *See id.*

[12] The trial court's declaration that a hospital need only demonstrate that total audited charges exceed $40,000 to be entitled to payment under the Stop–Loss Exception is contrary to the plain language of the rule. The rule states that the Stop–

Loss Exception was established to ensure compensation for unusually costly and unusually extensive services during a hospital admission. *See* Rule 134.401(c)(6). The rule also states that the stop-loss threshold was established to ensure compensation for unusually extensive services during a hospital admission. *Id.* § 134.401(c)(6)(A)(ii). The trial court's declaration eliminates the Division's ability under the rule to ensure that the Stop–Loss Exception provides compensation for unusually costly and unusually extensive services.

The trial court's declaration is inconsistent with other provisions in the rule. For example, the rule defines "Stop–Loss Payment" as an independent method of payment for an unusually costly or lengthy stay. *Id.* § 134.401(b)(1)(F). But the trial court's declaration precludes consideration of whether a hospital admission was unusually costly or lengthy. In addition, the rule states that $40,000 is the "*minimum* stop-loss threshold." *Id.* § 134.401(c)(6)(A)(i) (emphasis added). By its terms, this language suggests that there must be something more than a dollar amount to be considered when determining whether to apply the Stop–Loss Exception. The basic structure of the rule is consistent with this concept: The rule provides that reimbursement will be made under the standard per diem method unless an exception applies. *Id.* § 134.401(c)(2). The rule further states that independent reimbursement under the Stop–Loss Exception will be "allowed on a case-by-case basis." *Id.* § 134.401(c)(2)(C). This language suggests that the Stop–Loss Exception was meant to apply on a case-by-case basis in relatively few cases. Without consideration of whether an admission involves unusually costly or unusually extensive services, there can be no determination on a case-by-case basis, and the Stop–Loss Exception would mechanically apply in all cases where total audited charges exceeded $40,000. Reading the language of the rule as a whole, this cannot be what the Division intended.

The trial court's declaration is also contrary to the legislative mandate in the labor code because it precludes the Division from achieving effective medical cost control. Under the trial court's interpretation, the Division cannot limit the application of the Stop–Loss Exception to those cases involving unusually costly and unusually extensive services in which total audited charges exceed $40,000. When the Division adopted the 1997 guideline, it provided for a standard per diem reimbursement methodology with two exceptions. With the rise in health care costs as demonstrated by the record evidence in this case, the trial court's interpretation leads to the absurd and unreasonable result that reimbursement under the Stop–Loss *Exception* has replaced the standard per diem method as the general method of hospital reimbursement. Stated differently, the exception has now become the rule. We do not believe that this is what the Division intended when it adopted the 1997 guideline.

For these reasons, we conclude that the trial court's interpretation is contrary to the plain language of the rule, renders portions of the rule meaningless, and leads to results inconsistent with the intent of the statutory structure. A more reasonable interpretation of the rule is that to be eligible for reimbursement under the Stop–Loss Exception, a hospital must demonstrate that total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services. This interpretation is consistent with the plain language of the rule, which states that the stop-loss method was established to ensure fair and rea-

sonable compensation to the hospital for unusually costly and unusually extensive services. *Id.* § 134.401(c)(6), (c)(6)(A)(ii). It is likewise consistent with the interpretation urged by the Division in the 2005 Staff Report, which we address more fully below. And it is consistent with the basic structure of the rule, which calls for reimbursement under the standard per diem method except as allowed on a case-by-case basis under the Stop–Loss Exception. Accordingly, we sustain the carriers' challenge, reverse the trial court's declaration, and render judgment that the Stop–Loss Exception requires a hospital to demonstrate that total audited charges exceed $40,000 and that the admission involved unusually costly and unusually extensive services to receive reimbursement under the stop-loss method.

We emphasize that, in light of the legislative mandate in section 413.011 of the labor code requiring the Division to adopt fee guidelines designed to achieve both quality medical care and effective medical cost control, this is a more reasonable interpretation of the Stop–Loss Exception in Rule 134.401. Furthermore, because we adopt the construction of the rule urged by the carriers on appeal, we need not reach the carriers' alternative claims that the rule, as construed by the trial court, is an invalid delegation of the Division's legislative authority. Nor do we reach the carriers' claims that the rule, as interpreted by the trial court, is invalid because it fails to provide fair and reasonable reimbursement, fails to achieve effective medical cost control, or allows for reimbursement for medical services in excess of those amounts charged for similar treatment to individuals with an equivalent standard of living as required in section 413.011 of the labor code, or that the trial court's interpretation is inconsistent with the definition of "medical benefit" in labor code section 401.011(31).

[13, 14] To the extent certain carriers maintain that Rule 134.401 was invalid at its inception, or became invalid at some later date, because the rule is not based on Medicare reimbursement policies and methodologies and has not been reviewed and revised every two years, we find those claims to be without merit. While we agree with the carriers that section 413.011 of the labor code currently requires the Division to adopt medical fee guidelines that follow Medicare reimbursement policies and methodologies, *see* Tex. Lab.Code Ann. § 413.011(a), this requirement was not part of the statute when the Division adopted Rule 134.401 in 1997 and was not added until 2001. *See* Act of May 25, 2001, 77th Leg., R.S., ch. 1456, § 6.02, 2001 Tex. Gen. Laws 5167, 5185 (amending section 413.011(a) to require the Division to "adopt the most current reimbursement methodologies ... used by the federal Health Care Financing Administration").[8] Because this requirement was not part of the statute in 1997, the rule was not invalid at its inception for failing to meet this requirement. Nor do we believe that the rule became invalid at the moment this requirement was added to the statute in 2001.[9]

Similarly, we agree that section 413.012 states that the medical fee guidelines

8. This language was changed in 2005 from "Health Care Financing Administration" to "Centers for Medicare and Medicaid Services." Act of May 29, 2005, 79th Leg., R.S., ch. 265, § 3.233, 2005 Tex. Gen. Laws 469, 548.

9. "The measure of the validity of an agency rule is whether it is constitutional and whether it conforms to the procedural and substantive statutes applicable to its adoption." *Texas Dep't of Banking v. Restland Funeral Home, Inc.*, 847 S.W.2d 680, 683 (Tex.App.-Austin 1993, no writ).

"shall be reviewed and revised" every two years to reflect fair and reasonable rates and to reflect reasonable and necessary ranges of medical treatment. *See* Tex. Lab.Code Ann. § 413.012 (West 2006). But it does not follow that the Division's failure to review and revise the 1997 guideline every two years since it was adopted invalidates the rule.

[15–18] Although we generally construe the term "shall" as imposing a duty or obligation, *see* Tex. Gov't Code Ann. § 311.016 (West 2005), Texas courts have, in certain circumstances, construed "shall" to be directory. *See, e.g., Albertson's Inc. v. Sinclair,* 984 S.W.2d 958, 961 (Tex.1999). To determine whether the legislature intended a provision to be mandatory or directory, we consider the plain meaning of the words used, as well as the entire act, its nature and object, and the consequences that would follow from each construction. *See Schepps v. Presbyterian Hosp. of Dallas,* 652 S.W.2d 934, 936 (Tex. 1983) (citing *Chisholm v. Bewley Mills,* 155 Tex. 400, 287 S.W.2d 943, 945 (1956)). The supreme court has held that "provisions which are not of the essence of the thing to be done," but are directed instead towards the prompt and orderly conduct of business, are not generally considered mandatory. *Id.* When a statute is silent about consequences of noncompliance, we look to the statute's purpose in determining the proper consequence of noncompliance. *Id.* at 938. "If a provision requires that an act be performed within a certain time without any words restraining the act's performance after that time, the timing provision is usually directory." *Helena Chem. Co. v. Wilkins,* 47 S.W.3d 486, 495 (Tex.2001). Further, we liberally construe workers' compensation legislation to carry out its evident purpose of compensating injured workers and their dependents. *See Lujan v. Houston Gen. Ins. Co.,* 756 S.W.2d 295, 297 (Tex.1988); *Ward v. Charter Oak Fire Ins. Co.,* 579 S.W.2d 909, 910 (Tex.1979).

The legislature has provided no consequences for the Division's unfortunate noncompliance with the statutory directives in section 413.011 or 413.012 of the labor code. If the legislature had intended consequences for the failure to adopt Medicare reimbursement methodologies or the failure to review and revise the fee guidelines, it could have spelled out those consequences in the statute. With regard to the legislature's requirement that the Division adopt new *treatment* guidelines for injured workers, the legislature expressly provided that "[t]he treatment guidelines adopted under Chapter 413, in effect immediately before September 1, 2001, are abolished on January 1, 2002." *See* Act of May 25, 2001, 77th Leg., R.S., ch. 1456, § 6.09(b), 2001 Tex. Gen. Laws 5167, 5188. It speaks volumes that the legislature provided no consequences for the failure to adopt Medicare reimbursement methodologies or the failure to review and revise the fee guidelines every two years.

[19, 20] The carriers do not complain that the reimbursement rates under the 1997 guideline, as properly interpreted, are unreasonable. Nor have the carriers demonstrated harm from the application of the reimbursement rates in the 1997 guideline. Fee guidelines are just that—*guidelines.* They "merely assist carriers and, upon review, the [Division] in determining whether medical charges are 'fair and reasonable' or satisfy the applicable standard." *Methodist Hosp. v. Texas Workers' Comp. Comm'n,* 874 S.W.2d 144, 149–50 (Tex.App.-Austin 1994, writ dism'd w.o.j.). This Court has previously held that there is no private right to a fee guideline established by rule. *See Texas Workers' Comp. Comm'n v. East Side Surgical Ctr.,* 142 S.W.3d 541, 549 (Tex.App.-

Austin 2004, no pet.) ("East Side is only entitled to 'fair and reasonable' reimbursement-not to have the fee guidelines established by rule."). Accordingly, there can be no private right to an updated fee guideline or a guideline that uses a particular reimbursement methodology, so long as the reimbursement provided in the guideline is fair and reasonable. *See id.*

For these reasons, we conclude that the labor code's requirement to adopt fee guidelines that follow Medicare reimbursement methodologies and to review and revise these guidelines every two years are directory, not mandatory.[10] We further conclude that the Division's failure to comply with these statutory directives does not invalidate the 1997 guideline, or Rule 134.401.

2. "Unusually Costly" and "Unusually Extensive"

[21] Within their challenge to the trial court's interpretation of Rule 134.401, the carriers argue that the trial court erred in its determination that the terms "unusually costly" and "unusually extensive" are "so vague and uncertain that their use in determining whether the [Stop–Loss Exception] applies would be arbitrary." The carriers assert that such industry terms are knowable, calculable, and determinable and provide reasonably clear guidance to those parties affected by the rule.[11] We agree.

This Court has previously held that where an "idea embodied in a phrase is reasonably clear, a court should find it acceptable as a standard of measurement." *Texas Bldg. Owners & Managers Ass'n v. Public Util. Comm'n,* 110 S.W.3d 524, 535 (Tex.App.-Austin 2003, pet. denied). The supreme court has also recognized that a broad standard encompassing a multitude of factors will pass constitutional scrutiny if it is no more extensive than the public interest demands. *See Jordan v. State Bd. of Ins.,* 160 Tex. 506, 334 S.W.2d 278, 280 (1960); *Housing Auth. v. Higginbotham,* 135 Tex. 158, 143 S.W.2d 79, 87 (1940). Examples of standards upheld by Texas courts include "not worthy of public confidence," "unjust, fair, inequitable, misleading, deceptive," and "just and reasonable." *See Texas Bldg. Owners & Managers Ass'n,* 110 S.W.3d at 535 (citing cases).

We have held that Rule 134.401 requires a provider to demonstrate that the services it has provided are "unusually costly" and "unusually extensive" in order to be reimbursed under the stop-loss methodology. The phrases "unusually costly" and "unusually extensive" are no more vague or uncertain than other standards previously upheld by Texas courts. *See id.* (discussing standards and citing cases). They are no more vague or uncertain than other standards in the labor code requiring

10. We reject the carriers' argument that this Court's opinion in *Texas Medical Association v. Texas Workers Compensation Commission,* 137 S.W.3d 342 (Tex.App.-Austin 2004, no pet.), requires a different result. In *Texas Medical Association,* this Court stated that "the Commission has the ongoing statutory duty to review and revise the fee guidelines to ensure they are in compliance with the statutory factors," *see id.* at 350 (citing Tex. Lab. Code Ann. § 413.012 (West 2006)), but this Court did not consider whether that "ongoing duty" was mandatory or directory. *See id.* Nor did this Court consider the appropriate consequence for noncompliance with this "ongoing duty." Thus, our opinion in *Texas Medical Association* does not answer the question before us today-namely, whether this Court may invalidate an agency rule for noncompliance with a statutory directive when the legislature is silent.

11. The record demonstrates that MDROs, carriers, and hospitals understand and are familiar with these terms because they have been previously utilized and applied in other cases since the 1997 guideline was promulgated.

fee guidelines to be "fair and reasonable," "ensure quality medical care," and "achieve effective medical cost control." *See* Tex. Lab.Code Ann. § 413.011(d). What is unusually costly and unusually extensive in any particular fee dispute remains a fact-intensive inquiry best left to the Division's determination on a case-by-case basis. *See Texas Bldg. Owners & Managers Ass'n,* 110 S.W.3d at 536 (holding that what is "reasonable" and "nondiscriminatory" is fact-intensive inquiry best left to discretion of Public Utility Commission).

No party disputes that the labor code delegates authority to the Division to establish medical fee guidelines, resolve medical fee disputes, and "adjudicate the payment given the relevant statutory provisions and commissioner rules." *Id.* §§ 413.011(d) (establish fee guidelines), .031(c) (adjudicate payment due). The scope of this authority includes the discretion to establish appropriate standards for reimbursement and to determine whether those standards have been met. *Id.* §§ 413.011(d), .031(c); *see also Texas Bldg. Owners & Managers Ass'n,* 110 S.W.3d at 535–36 (commission's authority to require payment of "reasonable" and "nondiscriminatory" compensation includes power to determine what is reasonable and nondiscriminatory when dispute arises). To the extent the parties are dissatisfied with the Division's determination, the labor code provides for review by SOAH and appeal to the courts. *See* Tex. Lab.Code Ann. § 413.031(k).[12]

[22–24] There is no constitutional requirement that a statute or rule must define all of the terms used. *See Rooms with a View, Inc. v. Private Nat'l Mortgage Ass'n, Inc.,* 7 S.W.3d 840, 845 (Tex. App.-Austin 1999, pet. denied); *Garay v. State,* 940 S.W.2d 211, 219 (Tex.App.-Houston [1st Dist.] 1997, pet. ref'd). Recognizing the myriad of factual situations that may arise and allowing administrative agencies sufficient flexibility when drafting their rules, courts require no more than a reasonable degree of certainty defining what is required or prohibited. *See Pennington v. Singleton,* 606 S.W.2d 682, 689 (Tex.1980). Courts will invalidate an economic regulation "only if it commands compliance in terms so vague and indefinite as really to be no rule or standard at all ... or if it is substantially incomprehensible." *Ford Motor Co. v. Texas Dep't of Transp.,* 264 F.3d 493, 507 (5th Cir.2001) (internal quotation omitted); *see also Hoffman Estates v. Flipside, Hoffman Estates, Inc.,* 455 U.S. 489, 498, 102 S.Ct. 1186, 71 L.Ed.2d 362 (1982) ("Economic regulation is subject to a less strict vagueness test."). Applying these principles to Rule 134.401, we conclude that the phrases "unusually costly" and "unusually extensive" are sufficiently definite to provide guidance to the MDROs and ALJs who review and determine medical fee disputes on a case-by-case basis. *See Hoffman Estates,* 455 U.S. at 498, 102 S.Ct. 1186; *Commission for Lawyer Discipline v. Benton,* 980 S.W.2d 425, 437 (Tex.1998). Therefore, we sustain the carriers' challenge and reverse the trial court's declaration to the contrary.

3. 2005 Staff Report

[25] The carriers also challenge the trial court's determination that the 2005 Staff Report was an invalid and voidable rule. In its second declaration, the trial court held that the 2005 Staff Report was an administrative rule as defined in section 2001.003(6) of the government code, and that it was invalid and voidable because it

12. *See also* note 4 *supra* (explaining that between 2005 and 2007 the legislature provided for direct appeal to the courts without allowing an administrative hearing at SOAH).

was not adopted in compliance with government code sections 2001.0225 through 2001.034. *See* Tex. Gov't Code Ann. §§ 2001.003, .0225–.034 (West 2000) (defining "rule" and establishing rulemaking procedures). In its third declaration, the trial court invalidated the 2005 Staff Report because it found that the Division's use of the phrases "unusually costly" and "unusually extensive" in determining whether the Stop–Loss Exception applies would be arbitrary. The carriers urge this Court to reverse the trial court's declarations.

We agree with the carriers that the 2005 Staff Report is not an invalid and voidable rule. The APA defines a rule as "a state agency statement of general applicability that ... implements, interprets, or prescribes law or policy; or ... describes the procedure or practice requirements of a state agency." Tex. Gov't Code Ann. § 2001.003(6)(A). The APA definition of a rule includes "the amendment or repeal of a prior rule," but it does not include "a statement regarding only the internal management or organization of a state agency and not affecting private rights or procedures." *Id.* § 2001.003(6)(B)-(C).

As a preliminary matter, we conclude that the 2005 Staff Report was not a statement by a state agency. The 2005 Staff Report was a one-page document prepared by the director of the Medical Review Division within the Division that was intended to address an internal agency matter—namely, the inconsistent application of Rule 134.401. The 2005 Staff Report was presented to the Division at the January 2005 open meeting, but the Division simply thanked the director for the report and took no official action. The 2005 Staff Report recognized that the Division's MDROs had a history of inconsistently applying Rule 134.401, and proposed a correction to that internal inconsistency based on the language of Rule 134.401. For this reason, we conclude that the 2005 Staff Report was not a statement of the agency within the meaning of the APA.

[26] Even if we recognized the 2005 Staff Report as an agency statement, it is well-established that not every administrative pronouncement is a rule within the meaning of the APA. *See Texas Educ. Agency v. Leeper,* 893 S.W.2d 432, 443 (Tex.1994); *Brinkley v. Texas Lottery Comm'n,* 986 S.W.2d 764, 769 (Tex.App.-Austin 1999, no pet.). "This observation refers to the fact that administrative agencies routinely issue letters, guidelines, and reports, and occasionally file briefs in court proceedings, any of which might contain statements that intrinsically implement, interpret, or prescribe law, policy, or procedure or practice requirements." *Brinkley,* 986 S.W.2d at 769. If such statements were rules, an agency could not carry out its legislative functions: "How, under such a theory, could an agency practically express its views to an informal conference or advisory committee, or state its reasons for denying a petition to adopt a rule or file a brief in a court or agency proceeding?" *Id.*

[27] The supreme court in *El Paso Hospital District v. Texas Health and Human Services Commission,* 247 S.W.3d 709 (Tex.2008), analyzed whether an agency's interpretation of its own rule was also a rule.[13] In that case, the HHSC had interpreted its rule to impose a February 28th cutoff date when calculating Medicaid reimbursement rates. Under the rule's definition of "base year," the HHSC was required to use " '[a] 12–consecutive–month period of claims data,' to calculate the [h]ospitals' rates." *See id.* at 714 (quoting

13. It is undisputed that the Division has authority to interpret its own rules.

1 Tex. Admin. Code § 355.8063(b)(5)). The supreme court concluded that the February 28th cutoff was contrary to the rule's definition of base year because it excluded several claims from the calculation of the hospitals' rates and thus amended the plain language of the rule. *Id.* Because the HHSC had not followed APA rulemaking procedures to promulgate the February 28th cutoff, the supreme court also held that it was invalid and enjoined the HHSC from using the February 28th cutoff to calculate the hospitals' reimbursement rates. *Id.* at 715 (citing Tex. Gov't Code Ann. § 2001.035 (West 2000)).

Unlike the HHSC's interpretation in *El Paso Hospital District*, the 2005 Staff Report does not contradict Rule 134.401. Moreover, assuming the 2005 Staff Report is an agency statement, it is a statement regarding the agency's internal management that does not affect private rights. *See* Tex. Gov't Code Ann. § 2001.003(6)(C). The 2005 Staff Report is a statement regarding internal management because it is designed to correct MDROs' inconsistent application of the Stop–Loss Exception. It also allowed the agency to function effectively and produced clarity of direction in a highly technical area. The 2005 Staff Report did not affect private rights because it did not change or amend Rule 134.401; it simply mandated internal consistency when applying the rule.

We also reject the hospitals' argument that the 2005 Staff Report was a "new" interpretation of Rule 134.401. The record before us demonstrates that MDROs in the Division, as well as SOAH ALJs, had issued conflicting opinions interpreting and applying the Stop–Loss Exception in Rule 134.401 before the 2005 Staff Report was issued. Some MDROs and ALJs interpreted and applied the Stop–Loss Exception in the same manner as the 2005 Staff Report, and some did not. Because there were prior opinions and decisions interpreting and applying the Stop–Loss Exception in the same manner as the 2005 Staff Report, that report cannot, by definition, be a "new" interpretation of Rule 134.401.

For these reasons, we conclude that the 2005 Staff Report was not a rule within the meaning of the APA and, therefore, was not subject to APA rulemaking procedures. We sustain the carriers' challenge and reverse the trial court's declaration that the 2005 Staff Report was an invalidly adopted rule.

4. Reimbursement for Implantables, Orthotics, and Prosthetics

[28] The carriers also challenge the trial court's declaration that Rule 134.401 does not allow a carrier to audit a provider's charges for implantables, orthotics, and prosthetics to cost plus 10% when determining whether the $40,000 stop-loss threshold has been met. For the following reasons we overrule the carriers' challenge and sustain the trial court's judgment.

Rule 134.401 specifically carves out reimbursement for implantables, orthotics, and prosthetics. *See* Rule 134.401(b)(2)(B) (general information regarding additional reimbursements), (c)(4) ("Additional Reimbursements"). When medically necessary, implantables, orthotics, and prosthetics are reimbursed as "Additional Reimbursements" under the rule.[14] *Id.* § 134.401(c)(4)(A). As provided in the rule, implantables, orthotics, and prosthetics shall be reimbursed at the cost to the hospital plus 10%. *Id.* Rule 134.401 also

14. Also included in the category of "Additional Reimbursements" are magnetic resonance imaging (MRIs), computerized axial tomography (CAT scans), hyperbaric oxygen, blood, air ambulance, and pharmaceuticals. Rule 134.401(c)(4)(B)-(C).

provides that "[a]ll charges are subject to audit as described in the Commission rules." *Id.* § 134.401(b)(2)(C). Rule 134.401 provides that when *audited* charges exceed the $40,000 stop-loss threshold, the entire admission shall be reimbursed using the 75% stop-loss reimbursement factor. *Id.* § 134.401(c)(6)(A)(iii).

Reading these provisions together, we conclude that the charges for implantables, orthotics, and prosthetics must be audited before those charges can be used to determine whether the $40,000 stop-loss threshold has been met. The question then becomes audited to what? The carriers argue that these costs should be reduced, or audited, to cost plus 10% as specified in section 134.401(c)(4)(A). We do not believe this is what the Commission intended. Consider the following example: if the cost for implantables in a given admission was $40,000, under the carriers' interpretation, this cost would be audited to cost plus 10%, or $44,000, for purposes of determining whether the Stop–Loss Exception applied. Assuming that the admission involved unusually costly and unusually extensive services and because $44,000 is greater than $40,000, the Stop–Loss Exception would apply. Therefore, the entire admission would be reimbursed using the following formula:

Audited Charges × 75% SLRF [15] = WCRA [16]

See Rule 134.401(c)(6)(B). Applying this formula to the example, the hospital would be reimbursed only $33,000, or $7,000 less than its cost, for the implantables. Under this example, the hospital, or other provider, would incur a loss.

Because providers would incur losses under the carriers' proposed construction of the rule, that interpretation would be contrary to the statutory requirement that fee guidelines be "fair and reasonable." *See* Tex. Lab.Code Ann. § 413.011(d). We cannot construe the rule in a manner that is inconsistent with the statute. *See, e.g., CenterPoint Energy, Inc. v. Public Util. Comm'n,* 143 S.W.3d 81, 85 (Tex.2004) (observing that rule is invalid if it violates statutory provision); *Texas Workers' Comp. Comm'n v. Patient Advocates,* 136 S.W.3d 643, 657–58 (Tex.2004) (upholding rule as consistent with statute); *National Plan Adm'rs, Inc.,* 235 S.W.3d at 701 (courts should not construe statute in manner that leads to absurd results); *C & H Nationwide,* 903 S.W.2d at 322 n. 5 (same).

For these reasons, we conclude there was no error in the trial court's declaration that the costs for implantables, orthotics, and prosthetics should not be reduced to cost plus 10% when determining whether the $40,000 stop-loss threshold has been met. This is consistent with the plain language of the rule and section 413.011 of the labor code. It is likewise consistent with the trial court's judgment that a carrier is authorized to audit all hospital charges in accordance with applicable Division retrospective review rules, which we affirm because no party has challenged that declaration on appeal.

CONCLUSION

Having considered all of the parties' issues, we affirm the trial court's judgment that carriers may audit a provider's charges as permitted by the Division's rules and that a carrier may not reduce the charges for implantables, orthotics, and prosthetics to cost plus 10% when determining whether the Stop–Loss Exception applies. We reverse the trial

15. SLRF means "Stop–Loss Reimbursement Factor." *See* Rule 134.401(c)(6)(A).

16. WCRA means "Workers' Compensation Reimbursement Amount." *See id.*

court's judgment that the Stop–Loss Exception applies to any admission in which audited charges exceed $40,000, and we render judgment that, to establish eligibility for reimbursement under the Stop–Loss methodology, a provider must demonstrate that audited charges exceed $40,000 and that the services provided were unusually costly and unusually extensive so as to allow application of the exception. We also reverse the trial court's judgment that the 2005 Staff Report is an invalid rule and that the phrases "unusually costly" and "unusually extensive" are so vague and uncertain that their use by the Division in determining whether the Stop–Loss Exception applies would be arbitrary.