SOAH DOCKET NO. 453-03-0152.M4 – MDR Tracking No. M4-02-1932-01
SOAH DOCKET NO. 453-03-0499.M4 – MDR Tracking No. M4-02-4228-01

VISTA HEALTHCARE, INC.,	**§**	**BEFORE THE STATE OFFICE**
Petitioner	**§**	
	§	
v.	**§**	**OF**
	§	
TEXAS DEPARTMENT OF INSURANCE,	**§**	
DIVISION OF WORKERS' COMP.,	**§**	
& _____.	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Vista Healthcare, Inc. (Vista) requested a hearing to contest a decision by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) denying additional payment for ambulatory surgical center services.[1] Vista operated ambulatory surgical centers (ASCs) in Houston, Texas, and provided surgical services to patients not requiring in-patient hospitalization. As related to these dockets, Vista billed _____ (Carrier) for services provided to two claimants. Carrier reimbursed less than the billed amount and Vista requested medical dispute resolution before the MRD, which declined to order any additional payment for the services. In this docket, Vista has the burden of proving that it is entitled to additional payment for the services rendered. After considering all of the evidence and arguments, the Administrative Law Judge (ALJ) concludes that Vista has failed to meet that burden and is not entitled to additional reimbursement.

II. APPLICABLE LAW

The Texas Workers' Compensation Act (the Act) is found at TEX. LAB. CODE ANN. § 401.001, *et seq.* Under the Act, workers' compensation insurance covers all medically necessary health care, including all reasonable medical aid, examinations, treatments, diagnoses, evaluations,

[1] Effective September 1, 2005, the functions of the Commission were transferred to the newly-created Division of Workers' Compensation of the Texas Department of Insurance. This case arose before that transfer of authority, but only recently went to hearing because of related ongoing litigation that had a bearing on the handling of ambulatory surgical center cases.

and services reasonably required by the nature of the compensable injury and reasonably intended to cure or relieve the effects naturally resulting from a compensable injury.[2] Section 413.011 of the Act provides that the Commission by rule shall establish medical policies and guidelines relating to fees charged or paid for medical services for employees who suffer compensable injuries, including guidelines relating to payment of fees for specific medical treatments or services. Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.[3] Moreover, the guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. In setting the guidelines, the increased security of payment afforded by the Act must be considered.

During the time period relevant to this case, however, the Commission had yet to establish payment guidelines for ASC services. Absent such guidelines, an insurance carrier is required to reimburse the services at fair and reasonable rates as described in Section 413.011(d) of the Act.[4] Fair and reasonable is defined as:

> Reimbursement that meets the standards set out in § 413.011 of the Texas Labor Code, and the lesser of a health care provider's usual and customary charge, or
>
> > (A) the maximum allowable reimbursement, when one has been established in an applicable Commission fee guideline,
> >
> > (B) the determination of a payment amount for medical treatment(s) and/or service(s) for which the Commission has established no maximum allowable reimbursement amount, or
> >
> > (C) a negotiated contract amount.[5]

Thus, when the Commission has not established a fee guideline for a particular procedure, service, or item, the reimbursement amount is to be determined using the same factors used by the

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[2] TEX. LAB. CODE ANN. § 401.011(19) and (31). Unless otherwise noted, all cites to statutes and rules are to those in effect in 2001—during the relevant time periods in issue in this case.

[3] § 413.011(d) of the Act.

[4] 28 TEX. ADMIN. CODE (TAC) § 134.1(f).

[5] 28 TAC § 133.1(a)(8).

Commission in setting fee guidelines. The appropriate "fair and reasonable" reimbursement is the lowest one that ensures the quality of medical care and accounts for the factors used by the Commission in setting fee guidelines.

III. DISCUSSION AND ANALYSIS

Claimant in 453-03-0152.M4 sustained a compensable work-related injury on _____, and received care at a Vista ASC facility on _____. The procedure involved steroid injections. Vista billed Carrier 10,867.81 under CPT codes 62290 and 62311, and Carrier reimbursed Vista $1,624.35.

Claimant in 453-03-0499.M4 sustained a compensable work-related injury on _____, and received care at a Vista ASC facility on _____. The procedure at issue was related to removal of hardware from claimant's left wrist. Vista billed Carrier $8,904.18 under CPT code 20680, and Carrier reimbursed Vista $2,034.05.

The Carrier's reimbursement for these procedures was more than what the injured workers would have received if they had stayed overnight at an inpatient facility ($1,118) in accordance with the maximum allowable reimbursement (MAR) under the hospital fee guideline for an inpatient hospital billing for similar services. The MRD denied additional reimbursement. Vista appealed that decision and seeks a total reimbursement equal to 70% of its billed charges. As appellant, the burden of proof lies with Vista.

Vista's evidence of fair and reasonable reimbursement was a compilation of amounts billed and reimbursements it typically received from insurance carriers and governmental bodies for its ASC services. Vista argues that it is entitled to additional reimbursement here, because it historically has received a level of reimbursement from other insurance companies and Medicare that is higher than that offered by Carrier in this case. According to Vista's data, its average reimbursement rate for ASC services was approximately 60% of billed charges and its median reimbursement was 70% of billed charges. Additionally, at least one of Vista's contracts with a

health network (representing numerous insurance carriers) provided that Vista would be reimbursed at 70% of its billed charges.[6]

The compilation does not reflect a fair and reasonable rate of reimbursement for several reasons. First, Vista's witness, Jean Wincher,[7] testified that the records from which the compilation was made were incomplete due to flooding at the records warehouse. Second, some carriers mistakenly reimbursed Vista at greater than 100% of the bill, artificially inflating the amount of the average reimbursement. Third, there are wide variations in Vista's bills for the same procedure and even wider variations in carriers' reimbursements for the same procedures, completely undermining the idea that the compilation reflects a consistent standard for reimbursement. Fourth, Vista's witness could not testify as to the basis for costs or its markup in the bills. Finally, billed charges and historical reimbursement rates, by themselves, do not show compliance with the factors identified in Section 413.011 of the Act for determining a fair and reasonable reimbursement.

Although it may not be Vista's responsibility to consider the statutory factors in developing its usual and customary charges, it is Vista's burden to show that the reimbursement amount sought satisfies these factors and are fair and reasonable under the Act. Vista has failed to meet its burden. Vista's documentary evidence fails to show how 70% of its billed charges would comply with the statutory factors for determining a fair and reasonable reimbursement. So, the ALJ cannot conclude that Vista's charges are fair and reasonable in light of those factors.

Finally, the ALJ finds relevant the vast discrepancy between what Vista billed for the procedures in issue and the MAR for hospitals during the relevant time period, which was $1,118.00 for a patient's *overnight* stay, including charges for treatment, operating room, recovery room, medications, and supplies. Here, the Carrier reimbursed Vista an amount greater than that rate. While there may be reasons that ASCs are entitled to greater payment than hospitals, Vista has not adequately demonstrated that in this proceeding or justified such a vast discrepancy between its billings and the MAR for hospitals performing similar procedures. The ALJ is not persuaded that

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[6] Vista cited an agreement it had with Focus Healthcare Management for the Focus PPO Network, which paid 70% of billed charges.

[7] Ms. Wincher oversaw admissions, billing, and collections for Vista from 1996 to 2002.

ASCs, for a few hours of facility services, are entitled to three or four times the entire reimbursement for an overnight stay in a hospital.[8]

The evidence presented is insufficient for purposes of establishing that the amounts are fair and reasonable under the Act. To find otherwise would defeat the cost control element of § 413.011 of the Act. Because Vista has failed to show that its charges (or even 70% of its charges) in this case represent a fair and reasonable reimbursement under the applicable legal guidelines, the ALJ concludes that it is not entitled to any additional reimbursement. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.[9]

IV. FINDINGS OF FACT

1. The claimants addressed by this order received care at a Vista Healthcare (Vista) ASC facility for compensable, work-related injuries.

2. _____ (Carrier) is the insurance carrier responsible for the workers' compensation insurance benefits administered to the claimants.

3. Claimant in 453-03-0152.M4 was treated on _____ with steroid injections. Vista billed Carrier $10,867.81 under CPT codes 62290 and 62311, and Carrier reimbursed Vista $1,624.35.

4. Claimant in 453-03-0499.M4 was treated on _____ for removal of hardware from claimant's left wrist. Vista billed Carrier $8,904.18 under CPT code 20680, and Carrier reimbursed Vista $2,034.05.

5. In each instance, Carrier reimbursed an amount greater than the maximum allowable reimbursement (MAR) under the hospital fee guideline for a hospital billing for similar services, $1,118.

6. Vista sought additional reimbursement and submitted to the Texas Workers' Compensation Commission (Commission) a request for dispute resolution.

7. The Medical Review Division (MRD) of the Commission issued its Findings and Decision, ordering no additional reimbursement by Carrier.

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[8] Based on the operative reports, the approximate time for each procedure was 4.5 hours.

[9] The findings and conclusions apply to each of the dockets involved.

8. Vista requested a hearing, and the Commission issued a timely notice of hearing and referred the case to the State Office of Administrative Hearings (SOAH) for assignment of an Administrative Law Judge to hear the dispute.

9. All parties received adequate notice of not less than 10 days of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

10. On July 10, 2007, SOAH Administrative Law Judge, Steven M. Rivas held a contested case hearing concerning this docket at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Vista appeared through its attorney, Cristina Hernandez. Carrier appeared at the hearing through its attorney, Mark Sickles. The record remained open until July 31, 2007, after the parties submitted written closing arguments.

11. The reimbursements that Vista has received from different insurance carriers for the same services in issue in this proceeding have varied significantly.

V. CONCLUSIONS OF LAW

12. The Commission (now the Division of Workers' Compensation of the Texas Department of Insurance) has jurisdiction over this matter pursuant to the Texas Workers' Compensation Act. TEX. LAB. CODE ANN. § 413.031.

13. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

14. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

15. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

16. Workers' compensation insurance covers all medically necessary health care, which includes all reasonable medical aid, examinations, treatments, diagnoses, evaluations, and services reasonably required by the nature of the compensable injury, and reasonably intended to cure or relieve the effects naturally resulting from a compensable injury. It includes procedures designed to promote recovery or to enhance the injured worker's ability to get or keep employment. TEX. LAB. CODE ANN. § 401.011(19) and (31).

17. In this docket, Vista had the burden of proving by a preponderance of the evidence that it was entitled to additional reimbursement. 28 TEX. ADMIN. CODE (TAC) § 148.21(h).

18. Reimbursement for services not identified in an established fee guideline shall be reimbursed at *fair and reasonable* rates as described in the Texas Workers' Compensation Act, Section 8.21(b), until such time that specific guidelines are established by the commission. 28 TAC § 134.1(f).

19. Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing fee guidelines. TEX. LAB. CODE ANN. § 413.011.

20. A "usual and customary" charge may be the same as a "fair and reasonable" reimbursement amount only if there is evidence that the factors set out in § 413.011 of the Act are satisfied; that is, that the amount achieves effective medical cost control, taking into account payments made to others with an equivalent standard of living, and considering the increased security of payment. 28 TAC § 133.1(a)(8).

21. The records from which the spreadsheet compilations were made were incomplete due to flooding at the records warehouse.

22. Some carriers mistakenly reimbursed Vista at a greater than 100% of the bill, which artificially inflated the amount of the average reimbursement.

23. Vista's bills reflect wide variations for the same procedure and even wider variations in carriers' reimbursements for the same procedures.

24. Vista's witness could not testify as to the basis for the costs or its markup of the bills.

25. Billed charges and historical reimbursement rates alone do not show compliance with the factors identified in Section 413.011 of the Act for determining a fair and reasonable reimbursement.

26. Vista failed to show that its usual and customary billed charges, or even 70% of its billed charges, which is the amount sought by it in this proceeding, are fair and reasonable.

27. Vista has failed to show by a preponderance of the evidence that it is entitled to additional reimbursement for the services in issue in this proceeding.

ORDER

Having found that Vista has not shown itself entitled to relief from the orders of the Medical Review Division of the Texas Workers' Compensation Commission in the underlying cases, **IT IS, THEREFORE, ORDERED** that _____ is not required to provide any additional reimbursement for the services in issue in this docket.

SIGNED September 17, 2007.

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS