SOAH DOCKET NOS.
453-02-3513.M4 (MDR Tracking No. M4-02-2374-01)
453-03-3013.M4 (MDR Tracking No. M4-02-4164-01)
453-03-3088.M4 (MDR Tracking No. M4-02-4751-01)
453-03-3975.M4 (MDR Tracking No. M4-02-4958-01)
453-03-3976.M4 (MDR Tracking No. M4-03-0935-01)
453-04-5401.M5 (MDR Tracking No. M5-03-2507-01)
453-05-0605.M5 (MDR Tracking No. M5-03-0128-01)
453-05-0606.M5 (MDR Tracking No. M5-03-1630-01)
453-05-0607.M5 (MDR Tracking No. M5-02-2328-01)
453-05-0608.M5 (MDR Tracking No. M5-02-2269-01)

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
CENTRE INSURANCE CO.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Vista Healthcare, Inc. (Vista) requested a hearing to contest ten decisions 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 who did not require hospitalization. As related to these dockets, Vista billed Centre Insurance Company (Carrier) for services provided to ten patients. Carrier reimbursed less than the billed amount and Vista requested medical dispute resolution before the MRD, which issued orders declining to award additional payment for the services. Because all ten dockets involve the same issue, they were consolidated. The parties agreed that testimony and evidence in this hearing, excepting only the case-specific material, presented in the immediately preceding hearing in Dockets No. 453-03973.M4 and 453-03974.M4, would be the same as in the prior hearing.

This decision finds that Carrier's reimbursement methodology, payment of twice the hospital

[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. These cases arose before that transfer of authority, but only recently went to hearing because of ongoing litigation related to ambulatory surgical center workers' compensation cases.

maximum allowable recovery (MAR), was fair and reasonable. Therefore, Vista is not entitled to any additional reimbursement in the eight dockets in which Carrier paid the hospital MAR. In two dockets, however, Carrier made no reimbursement. In these two dockets, this decision finds that the same reimbursement methodology that Carrier applied in the other eight dockets is fair and reasonable, and orders Carrier to reimburse Vista $2,236.00 in both, for a total award of $4,472.

II. CONTESTED ISSUE AND BURDEN OF PROOF

In these dockets, Prehearing Order No. 1 placed the burden of proving that its reimbursement methodology is fair and reasonable on Carrier. If Carrier meets that burden, then it must prevail because its reimbursement is lower than that sought by Vista, and thus complies with the cost-control provisions of the Act discussed in Part III of this Decision. If Carrier does not meet its burden, then Vista has the burden of proving that its reimbursement methodology produced fair and reasonable results.[2] After reviewing the evidence and the parties' briefs, the Administrative Law Judge (ALJ) concludes that Carrier established that its reimbursements were fair and reasonable, and that Vista failed to meet that burden regarding its charges.[3]

III. APPLICABLE LAW

The Texas Workers' Compensation Act (the Act) is found at TEX. LAB. CODE ANN. § 401.001, *et seq.*[4] 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. That section further provides that 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.[5]

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[2] 28 TAC § 133.1(a)(8), repealed April 28, 2006. 31 Tex. Reg. 3543 (2006). Vista accepts the burden of proving that its methodology produces fair and reasonable reimbursement, but asserts that it cannot be required to prove that Carrier's requested reimbursement methodology is not fair and reasonable. (Vista Healthcare, Inc.'s Post-Trial Brief at p. 7.) The ALJ agrees, and assigns no such burden of proving a negative to Vista.

[3] Although, as previously stated, the ALJ believes that Carrier's prevailing on the fairness and reasonableness of its reimbursement methodology renders Vista's methodology moot, the latter finding is made in order to complete the record in the event of appeal.

[4] TEX. LAB. CODE ANN. § 401.011(19) and (31). Unless otherwise noted, all citations to statutes and rules are to those in effect in 2001, when the services at issue in this case were rendered.

[5] TEX. LABOR CODE ANN. § 413.011 provides as follows:

. . . (d) Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and

At the times relevant to this case, the Commission had not established fee guidelines for ASC services. In such a situation, an insurance carrier was required to reimburse the services at fair and reasonable rates as described in Section 413.011(d) of the Act.[6] For purposes of this proceeding, "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.[7]

Therefore, when the Commission has not established a maximum allowable reimbursement (MAR) in a fee guideline for a particular procedure, service, or item, the reimbursement amount is to be determined using the same factors used by the Commission in setting fee guidelines. The appropriate "fair and reasonable" reimbursement is one that ensures the quality of medical care and

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to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines. Notwithstanding Section 413.016 or any other provision of this title, an insurance carrier may pay fees to a health care provider that are inconsistent with the fee guidelines adopted by the division if the insurance carrier or a network under Chapter 1305, Insurance Code, has a contract with the health care provider and that contract includes a specific fee schedule.

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

(f) In addition to complying with the requirements of Subsection (e), medical policies or guidelines adopted by the commissioner must be:

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

[6] 28 TAC § 134.1(f), repealed effective May 1, 2004, 31 Tex. Reg. 3560 (2006).

[7] 28 TAC § 133.1(a)(8), repealed effective May 1. 2004, 31 Tex. Reg. 3543 (2006).

accounts for the factors used by the Commission in setting fee guidelines.

IV. DISCUSSION AND ANALYSIS

In each docket involved in this case, the claimant sustained a work-related injury. The compensability of the injuries is not in dispute. The claimants all received care at a Vista ASC facility. The physicians' charges are not in dispute in this proceeding, nor is there a dispute about the medical necessity of the treatments rendered. Rather, Vista seeks additional reimbursement beyond that awarded by the MRD for a total reimbursement equal to 70% of its billed charges, and the parties' dispute arises from the amount Vista billed for its facility charges.

In each docket, Vista billed Carrier what it alleges were its usual and customary charges, with the charges in each being as follows:

SOAH Docket No.	Vista Charge	Carrier Reimbursement[8]
453-02-3513.M4	$6,040.06	$2,959.22
453-03-3013.M4	$6,926.06	$2,236.00
453-03-3088.M4	$5,859.75	$2,236.00[9]
453-03- 3975.M4	$5,639.78	$2,236.00
453-03-3976.M4	$7,959.21	$0.00
453-04-5401.M5	$4,309.66	$2,236.00
453-05-0605.M5	$7,932.01	$2,236.00
453-05-0606.M5	$16,519.70	$2,236.00
453-05-0607.M5	$6,267.66	$2,236.00
453-05-0608.M5	$24,220.95	$0.00

[8] Carrier Ex. 3.

[9] Because the parties' records did not contain the charges and payments for this docket, the amounts for this docket are taken from the MRD decision, at page 2.

Through the testimony of its expert witness Nicholas Tsourmas, M.D.,[10] Carrier showed that its reimbursements to Vista in all but two dockets exactly doubled the $1,118 maximum allowable reimbursement (MAR) under the hospital fee guideline for a hospital billing for a patient's stay and similar treatment, including operating room, recovery room, medications, and supplies.

Carrier argues that Medicare payment policies have been accepted by the Texas Legislature as the basis for health care reimbursement policies and guidelines.[11] The Division of Workers' Compensation of the Texas Department of Insurance (DWC) has adopted 213.3% of the Medicare payment policies as a fair and reasonable maximum allowable recovery for ambulatory surgical centers' services such as those at issue in this proceeding.[12] Carrier asserts that such acceptance means that current ASC Fee Guidelines (ASCFG) are appropriate measures of the fairness and reasonableness of the services in dispute, even though those services were rendered before the Legislature recognized the Medicare guidelines as a basis for workers' compensation reimbursement.

The ALJ takes official notice of the ASCFG as an indication that such amounts are fair and reasonable. For the facility services rendered in the ten cases at issue, the current ASCFG is $213.3% of the Medicare Group 1 fee ($340), or $725.22. Thus, the payments by Carrier to Vista in each of the underlying dockets were approximately three times greater than the current ASCFG.

On the other hand, Vista argues that it should be reimbursed at 70% of its billed charges for the services at issue in these dockets because (1) it made a good faith effort to determine fair and reasonable charges in the absence of fee guidelines, and (2) historically, Vista has been reimbursed by other insurance companies and Medicare at that rate. Vista presented evidence of its billing practices and the amount of reimbursement it typically receives from other insurance carriers and governmental bodies for the ASC services it provides. Ms. Jean Wincher testified for Vista. Ms. Wincher is employed by a physicians' practice management, and acted as Vista's supervisor of

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[10] Carrier Ex. 4, deposition of N. F. Tsourmas, M.D. at pp. 40-46, 85-92 (April 20, 2007). The parties do not dispute that the services at issue are in Medicare Group 1.

[11] Act § 413.011(a).

[12] 28 TAC § 134.402(c).

collections and billings during the times of the services and charges at issue. She testified about the contents of a spreadsheet showing a partial history of payments received from all sources in the year 2001 for all CPT codes.

But, although Vista requests reimbursement of 70% of its charges, its own partial data (Ms. Wincher testified that as much as half of Vista's data was destroyed in a Houston flood) demonstrate that in 2001 Carriers reimbursed Vista at an average rate of only about 60% of its billed charges, although its partial numbers disclose that Vista was reimbursed at a median rate of 70% of its charges.[13] Ms. Wincher also testified that 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.

Vista's evidence does not support a finding that its billing methodology produced fair and reasonable charges. Ms. Wincher candidly admitted that Vista was sometimes reimbursed more than it billed for its ASC services. Ms. Wincher testified that these overpayments were mistakes and that Vista probably refunded the excess payments. However, because Vista's evidence includes these overpayments, they inflate its median reimbursement rate. And, as stated previously, the average reimbursement rate is 60%, not 70%, of Vista's charges. Vista provides no rationale for preferring the median over the average. Instead, as noted by Vista in its brief, DWC has preferred the average percent, not the median.[14]

Another issue also leads to the conclusion that Carrier met its burden of proof, while Vista did not. Vista's evidence of its billed charges and historical reimbursement rates are little evidence of compliance with the cost-containment factor identified in Section 413.011 of the Act for determining a fair and reasonable reimbursement. For example, while conceding that it billed amounts for the procedures at issue that greatly exceed the MAR for hospitals performing the same procedures, Vista offered no medical or economic evidence to justify the difference. On the other hand, Carrier's payments, while excessive, are closer to the standards that now define fair and reasonable charges.

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[13] Vista Rx. 8.

[14] Vista Healthcare, Inc.'s Post-trial Brief at pp. 10-11, and Commissioner Bulletin #B-0009-7, (May 1, 2007), quoted therein.

Vista showed that Carrier reimbursed it at amounts ranging from 28% to 78% of its billed charges,[15] and argues that Carrier did not apply its reimbursement methodology consistently, as required by prior Commission rule 133.304.[16] But as the table above shows, Vista's reimbursement in these dockets was perfectly consistent: it paid twice the hospital MAR for the same or similar services, $2,236.00, plus, in two cases, additional reimbursement of a few hundred dollars. The ALJ finds that Carrier's methodology, payment of twice the hospital maximum allowable recovery (MAR), complies with the factors identified in Section 413.011 and was fair and reasonable. Therefore, Vista is not entitled to any additional reimbursement in the eight dockets in which Carrier reimbursed it.

In the two dockets in which Carrier made no reimbursement, Carrier's methodology is also fair and reasonable. Carrier will be ordered to reimburse Vista $2,236.00 in each, for a total award of $4,472.[17]

V. FINDINGS OF FACT

1. Atlantic Mutual Insurance Company (Carrier) is the insurance carrier responsible for the workers' compensation insurance benefits administered to the claimants involved in Docket Nos. 453-02-3513.M4, 453-03-3013.M4, 453-03-3088.M4, 453-03- 3975.M4, 453-03-3976.M4, 453-04-5401.M4, 453-05-0605.M4, 453-05-0606.M4, 453-05-0607.M4, and 453-05-0608.M4 ("underlying dockets").

2. Each of the claimants involved in the ten dockets addressed by this Decision and Order received care at a Vista ambulatory surgical center facility (ASC) for their compensable, work-related injuries.

3. Vista billed Carrier, and Carrier reimbursed Vista, for services provided to each of the ten claimants, as follows:

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[15] Vista Ex. 8.

[16] Vista Healthcare, Inc.'s Post-Trial Brief at pp 11-12. The rule at 28 TAC § 133.304 was repealed effective May 1, 2006. 31 Tex. Reg. 3544 (April 28, 2006).

[17] Most findings and conclusions apply to each of the dockets involved. Because the outcome of this case does not rest on any claimant-specific circumstances, the ALJ makes no specific findings related to the individual claimants or their injuries.

SOAH Docket No.	Vista Charge	Carrier Reimbursement
453-02-3513.M4	$6,040.06	$2,959.22
453-03-3013.M4	$6,926.06	$2,236.00
453-03-3088.M4	$5,859.75	$2,236.00[18]
453-03- 3975.M4	$5,639.78	$2,236.00
453-03-3976.M4	$7,959.21	$0.00
453-04-5401.M5	$4,309.66	$2,236.00
453-05-0605.M5	$7,932.01	$2,236.00
453-05-0606.M5	$16,519.70	$2,236.00
453-05-0607.M5	$6,267.66	$2,236.00
453-05-0608.M5	$24,220.95	$0.00

4. In each docket, Vista sought additional reimbursement and submitted to the Commission a request for dispute resolution.

5. The Medical Review Division of the Texas Workers' Compensation Commission (MRD) issued its Findings and Decision in each of the ten dockets, ordering no additional reimbursement by Carrier.

6. Vista timely requested a hearing in each docket, and the Commission issued a timely notice of hearing and referred the cases to the State Office of Administrative Hearings for assignment of an Administrative Law Judge to hear the disputes.

7. Both 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.

8. On July 19, 2007, SOAH Administrative Law Judge Charles Homer III held a contested case hearing concerning the ten referenced dockets at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Carrier appeared at the hearing through its attorney, Steven M. Tipton. Vista appeared through its attorney, Christina Hernandez. The record closed on July 26, 2007, after the parties submitted closing written arguments.

9. The amount that Carrier reimbursed Vista in each docket except two exceeds the maximum allowable reimbursement (MAR) under the hospital fee guideline for a hospital billing for similar services.

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[18] Because the parties' records did not contain the charges and payments for this docket, the amounts for this docket are taken from the MRD decision, at page 2.

10. Medicare payment policies have been accepted by the Texas Legislature as the basis for fair and reasonable maximum allowable recoveries for ambulatory surgical centers' services such as those at issue in this proceeding.

11. Although not in effect at the time of the services rendered, the subsequent adoption by the Division of Workers' Compensation of the Texas Department of Insurance of fee guidelines for ambulatory surgical centers is an indication that those guidelines are fair and reasonable.

12. Payments by Carrier to Vista in all but two of the underlying dockets approximately tripled the fee guidelines for ambulatory surgical centers ($725.22) that is based on Medicare payment policies for the services performed for Claimants at ambulatory surgical centers.

13. Vista failed to show that 70% of its billed charges is a fair and reasonable reimbursement.

VI. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (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. (Act) § 413.031.

2. The State Office of Administrative Hearings 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.

3. In each case involved in this proceeding, the request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

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

5. 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) (Emphasis added).

6. In each of the ten dockets in this proceeding, Carrier had the burden of proving by a preponderance of the evidence that its reimbursement methodology was fair and reasonable. Act § 413.031(d); 28 TEX. ADMIN. CODE (TAC) § 134.402; 1 TAC § 155.41(b).

7. 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. Act § 413.011.

8. 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), repealed April 28, 2006. 31 Tex. Reg. 3543 (2006).

9. Carrier's methodology, payment of twice the hospital maximum allowable recovery (MAR), complies with the factors identified in Act § 413.011, and was fair and reasonable.

10. Based on Findings of Fact Nos. 3, 9, 10, 11, and 12, Carrier established that its reimbursement in each docket was fair and reasonable, except in Docket Nos. 453-03-3976.M4 and 453-05-0608.M5.

11. Vista is entitled to reimbursement of $2,236.00 in each of Docket Nos. 453-03-3976.M4 and 453-05-0608.M5.

ORDER

Carrier's methodology provided reimbursements to Vista that are at least fair and reasonable amounts for the disputed charge in each docket except for the two in which Carrier paid no reimbursement. Therefore, Vista is not entitled to any additional reimbursement in the eight dockets in which Carrier reimbursed it, but is entitled to reimbursement according to the same methodology in Docket Nos. 453-03-3976.M4 and 453-05-0608.M5.

Therefore, **IT IS, THEREFORE, ORDERED** that Carrier reimburse Vista Healthcare, Inc., $2,236.00 for services rendered Claimant in each of Docket Nos. 453-03-3976.M4 and 453-05-0608.M5, for a total award of $4,472.00.

IT IS FURTHER ORDERED that Centre Insurance Company is not required to pay any additional reimbursement for the services in issue in the remaining eight dockets in this proceeding.

SIGNED September 24, 2007.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS