SOAH DOCKET NO. 453-03-0571.M4 – MDR Tracking No. M4-02-1950-01
SOAH DOCKET NO. 453-03-0572.M4 - MDR Tracking No. M4-02-2372-01

SOAH DOCKET NO. 453-03-3017.M4 - MDR Tracking No. M4-02-3788-01

SOAH DOCKET NO. 453-03-3092.M4 - MDR Tracking No. M4-02-4615-01
SOAH DOCKET NO. 453-03-3896.M4 - MDR Tracking No. M4-03-0154-01
SOAH DOCKET NO. 453-05-1461.M4 - MDR Tracking No. M4-03-0852-01

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	
	§	**OF**
ST. PAUL FIRE AND MARINE	§	
INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Vista Healthcare, Inc., (Vista) requested a hearing to contest decisions by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission)[1] denying additional payment for ambulatory surgical center (ASC) services. Vista operated ASCs in the Houston area that provided outpatient surgical services to patients not requiring hospitalization. Vista billed St. Paul Fire and Marine Insurance Company (Carrier) for services provided to six different claimants in 2001.[2] Carrier reimbursed less than the billed amount, and Vista requested medical dispute resolution before MRD, which declined to order additional payment for the services. In this proceeding, Vista has the burden of proving that it is entitled to additional payment for the services provided. After considering all of the evidence and arguments,[3] the Administrative Law Judge (ALJ) concludes that Vista failed to meet its burden and therefore, is not entitled to any additional reimbursement.

[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.

[2] Because the cases were heard together, the ALJ is issuing a single decision in the six above-captioned cases.

[3] The ALJ admits into the record Vista Exs. 1, 2, 4, and 6 in Docket No. 453-05-1461.M4, which Vista filed on June 15, 2007.

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, 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.[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] 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 such guidelines, the increased security of payment afforded by the Act must be considered.

During the time period relevant to this proceeding, however, the Commission had not established a fee payment guideline for ASC services. In such a situation, reimbursement for such services was to be provided at a fair and reasonable rate as described in Section 413.011(d) of the Act.[6] 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

[4] 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 period at issue in this case.

[5] § 413.011(d) of the Act.

[6] 28 TAC § 134.1(f).

> (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 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 the lowest amount that ensures the quality of medical care and accounts for the factors used by the Commission in setting fee guidelines. Vista had the initial burden of providing "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement."[8]

III. DISCUSSION AND ANALYSIS

In each of the six cases at issue, the claimant sustained a work-related injury. The claimants all received care at a Vista ASC facility. The compensability of the injuries is not in dispute. The physicians' charges are not in dispute; nor is there a dispute about the treatments given. The amounts billed by Vista for its facility charges associated with the procedures performed by the treating physicians are in dispute.

In each of the cases, Vista billed Carrier its usual and customary charges, ranging from $4,572.09 to $17,137.90, depending on the procedure performed. Carrier reimbursed the services at $1,118.00, which is the per diem reimbursement amount for 24 hours of surgical care in a hospital.

Vista is seeking additional reimbursement that would provide it with a total

[7] 28 TAC § 133.1(a)(8).

reimbursement equal to 70 percent of its billed charges. Vista argues that because it historically received 70 percent of its billed charges from many insurance carriers, including carriers reimbursing under negotiated contracts, that amount represents fair and reasonable compensation. To establish its payment history, Vista relied on the testimony of Jean Wincher, who was Vista's administrator. She oversaw admissions, billing, and collections for Vista. Ms. Wincher testified that Vista billed its usual and customary charges. Vista also presented evidence in the form of a spreadsheet created by its business office showing that the history of payments yielded an average reimbursement rate of 60 percent of billed charges. Ms. Wincher testified that the average is less than the 70 percent expected because many billing records were lost during hurricane Rita.

The ALJ is not persuaded, however, that the evidence presented of Vista's billing practices and what it typically received in reimbursement for its services establishes a fair and reasonable reimbursement rate. 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. For one thing, no evidence was presented showing that the billed charges were reasonably based. Furthermore, Vista's reliance on the data from the other payors is misplaced because the record is silent as to why the other payors agreed to pay Vista the amounts they did. There is no evidence that Vista inquired into the reasons for the reimbursement paid by other payors or that it conducted any analysis of how its rates–regardless of their derivation–complied with the state's statutory scheme. And although the amounts that other carriers paid may be some indication of what might be a fair and reasonable amount, by itself that information is not dispositive. There can be many reasons why a carrier might reimburse at a rate higher than what would be reasonable, including mistakes.

Vista's spreadsheet reflects a number of reimbursement mistakes, including those over

[8] 28 TAC § 133.305(e)(1)(F).

100 percent. In one such instance a carrier paid 170 percent of the billed charges.[9] Although carriers were reimbursed for overpayments, the calculation was not changed and the average reimbursement percentage is, therefore, artificially inflated. Furthermore, the percentage of billed charges depends substantially on Vista's billing practices, and not on the amounts paid by the payers. Vista routinely billed Medicare pursuant to the Medicare guideline in effect at that time since it knew what the amount of those reimbursements would be. *See, e.g.,* Vista Ex. 8 at 22, ln. 878, showing reimbursement at 100 percent for the billed charges of $312.43, which also served to artificially inflate the average percentage. But Vista billed a carrier $6,674.10 for the same service.[10] The spreadsheet also shows that Vista received payments as low as 2 percent, showing that payment of 70 percent of billed charges was not a universal practice in the industry.[11]

Furthermore, that a number of carriers were willing to reimburse Vista at 70 percent of its billed charges is not indicative of fair and reasonable reimbursement because it does not achieve effective cost control pursuant to Section 413.011 of the Act. The Commission has previously rejected a "percentage of billed charges" methodology for determining fair and reasonable reimbursement amounts for hospitals because it does not comply with the statutory directive of cost control. As early as 1997, the Commission rejected reimbursement based on what hospitals charged because they allowed the providers "to affect their reimbursement by inflating their charges" and rejected the "discount from billed charges" approach, "because it leaves the ultimate reimbursement in the control of the [provider], thus defeating the statutory objective of effective cost control" and "provides no incentive to contain medical costs."[12]

In addition, Vista failed to provide any evidence that payment of 70 percent of billed charges is necessary for employees to obtain access to ASC services in the Houston area and that the percentage takes into consideration the increased security afforded by workers' compensation

[9] Vista Ex. 8 at 2, ln. 42. *See also* lns. 52 and 60, showing overpayments of 110 percent and 129 percent.
[10] Vista Ex. 8 at 9, ln. 336.
[11] Vista Ex. 8 at 22, ln. 877.

payments.

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 amounts it seeks satisfy those factors and, thus, are fair and reasonable under the Act. In this case, Vista's evidence has not established its burden. Ms. Wincher could not identify any of the statutory factors to consider when determining a fair and reasonable reimbursement, and none of its documentary evidence shows how 70 percent of its billed charges would comply with the statutory factors for determining a fair and reasonable reimbursement. Accordingly, the ALJ cannot conclude that Vista's charges are fair and reasonable in light of the factors identified in Section 413.011.

Further, the ALJ finds relevant the discrepancy between the amounts Vista billed for the procedures at issue and the maximum allowable reimbursement (MAR) for hospitals during the relevant time period—which was $1,118.00 a day for a patient's stay and treatment, including operating room, recovery room, medications, and supplies. Nicholas Tsourmas, M.D., an orthopedic surgeon, testified that the procedures performed in ASCs are simple, recurring procedures, including epidural steroid injections that take just ten minutes to perform.[13] Dr. Tsourmas also testified that paying the hospital per diem of $1,118.00 would more than fairly compensate ASCs for their services.[14] While there may be reasons that an ASC would be entitled to greater payment than a hospital, Vista did not adequately show that to be the case here or otherwise justified such a vast discrepancy between its billings and the MAR for hospitals performing similar procedures. The ALJ is not persuaded that ASCs are entitled to more than three or four times the reimbursement for hospitals providing full day stays for a half day's worth of facility services. Vista's billings appear exorbitant, and Vista has not justified them, except to say that the market has been willing to pay those amounts in the past. This is insufficient for

[12] 22 Tex. Reg. at 6262, 6268, and 6276 (1997).
[13] Carrier's Ex. 9 at 142.
[14] Carrier's Ex. 9 at 158.

purposes of establishing that the amounts are fair and reasonable under the Act.

Therefore, because Vista failed to show that its charges (or even 70 percent of its charges) in this case represent a fair and reasonable reimbursement amount according to 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.[15]

IV. FINDINGS OF FACT

1. Each of the claimants involved in the six cases addressed by this order received outpatient surgical care at a Vista Healthcare, Inc. (Vista) Ambulatory Surgical Center (ASC) facility for their compensable, work-related injuries.

2. St. Paul Fire & Marine Insurance Company (Carrier) is the insurance carrier responsible for the workers' compensation insurance benefits administered to each of the claimants.

3. Vista billed Carrier its usual and customary charges for the services provided to each of the six claimants, with those charges ranging from a low of $4,572.09 to a high of $17,137.90, depending on the procedure performed.

4. Carrier reimbursed the services at $1,118.00, which is the per diem reimbursement amount for 24 hours of surgical care in a hospital.

5. Vista sought additional reimbursement and submitted to the Texas Workers' Compensation Commission (Commission) a request for dispute resolution in each of the six cases.

6. The Commission's Medical Review Division issued its Findings and Decision in each of the six cases, ordering no additional reimbursement by Carrier.

7. Vista requested a hearing in each case, and the Commission issued proper hearing notices and referred the cases to the State Office of Administrative Hearings (SOAH) for assignment of an Administrative Law Judge to hear the disputes.

8. All parties received adequate notice of not less than 10 days of the time, place, and nature

[15] The findings and conclusions apply to each of the cases 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.

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.

9. On June 8, 2007, SOAH Administrative Law Judge Katherine L. Smith held a contested case hearing concerning the six above-referenced cases at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Carrier appeared at the hearing through its attorney, Steve Tipton. Vista appeared through its attorney, Cristina Hernandez. The record closed on July 13, 2007, after the parties submitted written closing arguments.

10. Vista seeks reimbursement in the amount of 70 percent of its billed charges.

11. The willingness of some carriers to pay at or near the billed amount does not establish that the billed amount is fair and reasonable.

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

13. The amount Vista billed the Carrier and the amount it now seeks in reimbursement far exceed the amount of reimbursement that a hospital would receive for the same procedure.

V. CONCLUSIONS OF LAW

1. 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.

2. 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.

3. In each case at issue in this proceeding, the request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE (TAC) § 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. 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).

6. In each of the six cases in this proceeding, Vista had the burden of proving by a preponderance of the evidence that it was entitled to additional reimbursement. 28 TAC § 148.21(h).

7. 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).

8. 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.

9. 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).

10. Vista was required to show that the reimbursement it seeks is fair and reasonable, and its historical billings and reimbursement rates by themselves do not show compliance with the factors identified in Section 413.011 of the Act or the Commission's rules for determining a fair and reasonable reimbursement.

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

12. Vista's charges were excessive.

13. 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 St. Paul Fire & Marine Insurance Company is not required to provide any additional reimbursement for the services at issue in the six cases in this proceeding.

SIGNED September 11, 2007.

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KATHERINE l. SMITH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS