**SOAH DOCKET NO. 453-03-0143.M4**
**MDR Tracking No. M4-02-2588-01**
**SOAH DOCKET NO. 453-03-3098.M4**
**MDR Tracking No. M4-02-4619-01**
**SOAH DOCKET NO. 453-05-1535.M4**
**MDR Tracking No. M4-03-1314-01**
**SOAH DOCKET NO. 453-05-1536.M4**
**MDR Tracking No. M4-03-0285-01**

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| **VISTA HEALTHCARE, INC.,** | § | **BEFORE THE STATE OFFICE** |
| **Petitioner** | § | |
| | § | |
| **v.** | § | **OF** |
| | § | |
| **TWIN CITY FIRE INSURANCE CO.,** | § | |
| **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) 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 Twin City Fire Insurance Company (Carrier) for services provided to four different patients.[2] Carrier reimbursed less than the billed amount and Vista requested medical dispute resolution before MRD, which subsequently 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.[3] After considering all of the evidence

[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.

[2] Because these cases were heard together, the ALJ issues this single decision in the four dockets involved.

[3] Despite Vista's assertion to the contrary, Carrier has no burden of proof in this matter. It is Vista that seeks a higher level of reimbursement than that already approved by MRD. Accordingly, the ALJ will order no additional

and arguments, the Administrative Law Judge (ALJ) concludes that Vista has failed to meet that burden; therefore, it is not entitled to any 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, 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.

However, during all time periods relevant to this case, the Commission had not established any payment guidelines for ASC services. In such a situation, an insurance carrier is required to reimburse the services at fair and reasonable rates as described in Section 413.011(d) of the Act.[6] Fair and reasonable is defined as:

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reimbursement unless Vista shows itself entitled to such.

[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 periods in issue in this case.

[5] § 413.011(d) of the Act.

[6] 28 TAC § 134.1(f).

> 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 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 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

In each of the four dockets 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 performing the treatments billed Carrier, and the physicians' charges are not in dispute in this proceeding; nor is there a dispute about the treatments given. Rather, what is in dispute is the amount billed separately by Vista for its facility charges associated with the procedures performed by the treating physicians.

In each of the dockets, Vista billed Carrier its usual and customary charges, ranging from a low of $5,129.28 to a high of $14,074.66, depending on the surgery performed. Carrier reimbursed the sum of $1,118 in each instance—an amount equal to the maximum allowable reimbursement (MAR) under the hospital fee guideline for a hospital billing for similar services. In this matter,

[7] 28 TAC § 133.1(a)(8).

Vista seeks additional reimbursement that would provide it a total reimbursement equal to 70% of its billed charges.

To support its request for additional reimbursement, Vista has 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. Vista argues that it is entitled to additional reimbursement essentially 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. In particular, according to the data presented by Vista, its average reimbursement rate for ASC services has been approximately 60% of billed charges. Further, its median reimbursement has been 70% of billed charges.[8] In fact, 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.[9] Based on this evidence, Vista argues that it is entitled to be reimbursed at 70% of its billed charges for the services at issue in these dockets.

The ALJ is not persuaded, however, that Vista's evidence of its billing practices and what it typically has 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. The amounts that other carriers have paid may be some indication of what might be a fair and reasonable amount, but by itself that information is not dispositive under the statutory guidelines.[10]

There can be many reasons why a carrier might reimburse higher than what would be reasonable

[8] In essence, half of all procedures were reimbursed at higher than 70% of billed charges, while half were reimbursed at less than 70% of billed charges. See Petitioner's Ex. 1.

[9] Tr. at 33-35.

[10] In fact, the Commission has previously rejected a "percentage of billed charges" methodology for determining fair and reasonable reimbursement amounts because it does not comply with the statutory directive of cost control.

under a certain circumstance, not the least of which is simply "mistake."

In fact, Vista's evidence reflects that reimbursement mistakes were commonly made. On numerous occasions, Vista was reimbursed more than it billed for its ASC services. When questioned as to why this would happen, Vista's witness at the hearing testified that these were overpayments by mistake and the excess payments were probably refunded by Vista.[11] However, because Vista's evidence includes these overpayments, the average reimbursement rate is artificially inflated by them.

Moreover, Vista's data shows wide variations between the reimbursements by different carriers. While payment data might be indicative of a fair and reasonable amount if it is uniformly consistent, it provides little persuasive value when it shows wide variations in reimbursement amounts. For example, take the procedure identified as a knee arthroscopy (CPT Code 29880), for which Vista billed $13,956.15 in regard to one of the claimants in this case. Vista's evidence shows no uniformity in how that procedure was reimbursed. The chart below shows an example of the amounts billed, amounts paid, and percentage of billed charges paid, as reflected on Vista's evidence:[12]

| Amount Billed | Amount Paid | Percentage of Billed Charges |
|---|---|---|
| $13,428.53 | $1,141.65 | 9% |
| $13,926.88 | $11,660.04 | 84% |
| | | |

[11] Tr. at 52-53; *see also* Petitioner's Ex. 1.

[12] Petitioner's Ex. 1, at 6.

| | | |
|---|---|---|
| $13,680.87 | $1,657.55 | 12% |
| $13,723.66 | $900.00 | 7% |
| $12,474.40 | $10,643.37 | 85% |
| $15,089.39 | $12,007.31 | 80% |

This same discrepancy is shown in nearly all of the other procedures identified in Vista's data sheet. For example, for the procedure identified as "cervical, thoracic injection" (CPT Code 62310), Vista's data shows only two procedures performed. They were performed within a week of each other and the billed charges were within approximately 10% of each other. However, one was reimbursed at 49% of billed charges, while the other was reimbursed at 88% of billed charges. The difference between the two reimbursements was more than $2,000 on a procedure that was billed at approximately $5,000.[13] This type of difference permeates Vista's data, thus reducing its value for showing a fair and reasonable rate of 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, thus, are fair and reasonable under the Act. In this case, Vista's evidence has not established this. Its only witness could not identify any of the statutory factors to consider when determining a fair and reasonable reimbursement,[14] and none of its documentary evidence shows how 70% of its billed charges would comply with the statutory factors for determining a fair

[13] Petitioner's Ex. 1, at 19. This is not one of the procedures involved in this case, but it is particularly demonstrative of the wide variations in reimbursement because of the similarity in the dates of service and billed charges for the procedure.

[14] Tr. at 49.

and reasonable reimbursement. So, 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 vast discrepancy between what Vista billed for the procedures in issue and the MAR for hospitals during the relevant time periods—which was $1,118.00 a day for a patient's stay and treatment, including operating room, recovery room, medications, and supplies. 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 ASCs—for a few hours' worth of facility services—are entitled to more than three or four times the reimbursement for hospitals providing full day stays. 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 purposes of establishing that the amounts are fair and reasonable under the Act. Therefore, 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.[15]

## IV. FINDINGS OF FACT

1. Each of the claimants involved in the four dockets addressed by this order received care at a Vista ASC facility for their compensable, work-related injuries.

2. The claimants each received a different surgical procedure; the four primary surgical services involved in this case are (1) discogram (CPT Code 62290); (2) caudal injections (CPT Code 62311); (3) arthroscopy (CPT Code 29819); and (4) knee arthroscopy (CPT Code 29880).

3. Twin City Fire Insurance Company (Carrier) is the insurance carrier responsible for the

[15] The 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.

workers' compensation insurance benefits administered to each of the claimants.

4. Vista billed Carrier its usual and customary charges for the services provided to each of the four claimants, with those charges ranging from a low of $5,129.28 to a high of $14,074.66, depending on the surgery performed.

5. Carrier reimbursed the sum of $1,118 in each instance—an amount equal to the maximum allowable reimbursement (MAR) under the hospital fee guideline for a hospital billing for similar services.

6. Vista sought additional reimbursement and submitted to the Commission a request for dispute resolution in each of the four dockets.

7. MRD issued its Findings and Decision in each of the four dockets, ordering no additional reimbursement by Carrier.

8. Vista 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.

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 May 23, 2007, SOAH Administrative Law Judge Craig R. Bennett held a contested case hearing concerning the four 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, Steve Tipton. Vista appeared through its attorney, Cristina Hernandez. The record closed on June 11, 2007, after the parties submitted closing written 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 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. § 413.031.

13. 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.

14. In each case in issue in this proceeding, 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 each of the four dockets in this proceeding, 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) (Emphasis added).

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. 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.

22. 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 Twin City Fire Insurance Company is not required to provide any additional reimbursement for the services in issue in the four dockets in this proceeding.

**SIGNED June 12, 2007.**

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