SOAH DOCKET NOS.
453-03-0563.M4 - MDR Tracking No. M4-02-2975-01
453-03-0565.M4 - MDR Tracking No. M4-02-3759-01
453-03-0566.M4 – MDR Tracking No. M4-02-2627-01
453-03-0567.M4 – MDR Tracking No. M4-02-4190-01
453-03-0569.M4 – MDR Tracking No. M4-02-2855-01
453-03-0570.M4 – MDR Tracking No. M4-02-3805-01
453-03-3692.M4 – MDR Tracking No. M4-02-2826-01
453-03-3095.M4 – MDR Tracking No. M4-02-4734-01
453-03-3691.M4 – MDR Tracking No. M4-02-4867-01
453-03-3693.M4 – MDR Tracking No. M4-03-0013-01

453-03-3694.M4 – MDR Tracking No. M4-03-0078-01

453-03-3696.M4 – MDR Tracking No.
453-03-3697.M4 – MDR Tracking No.
453-03-3698.M4 – MDR Tracking No.
453-05-1511.M4 – MDR Tracking No. M4-03-0876-01
453-05-1512.M4 – MDR Tracking No. M4-03-0901-01
453-05-1514.M4 – MDR Tracking No. M4-03-0917-01
453-05-1526.M4 – MDR Tracking No. M4-03-0886-01
453-05-1530.M4 – MDR Tracking No. M4-03-3812-01

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
	§	
TRAVELERS INDEMNITY CO.	§	
OF CONNECTICUT,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

SOAH DOCKET NOs. 453-05-1519.M4 – MDR Tracking No. M4-03-1066-01
AND 453-05-1520.M4 – MDR Tracking No. M4-03-0343-01

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
	§	
TRAVELERS INDEMNITY COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

SOAH DOCKET NO. 453-05-1515.M4 – MDR Tracking No. M4-03-0884-01

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
	§	
TRAVELERS CASUALTY & SURETY	§	
COMPANY OF ILLINOIS,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

SOAH DOCKET NO. 453-05-1518.M4 – MDR Tracking No. M4-03-6375-01

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
	§	
TRAVELERS CASUALTY &	§	
SURETY CO.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

SOAH DOCKET NOS. 453-03-3904.M4 – MDR Tracking No. M4-02-4957-01
AND 453-05-1463.M4 – MDR Tracking No. M4-03-10930-01

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
	§	
STANDARD FIRE 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 Texas, providing surgical services to patients not requiring in-patient hospitalization. In this consolidated docket, Vista billed for services provided to 25 different patients.[2] For each such patient, Travelers Insurance[3] (Carrier) reimbursed less than the billed amount, and Vista requested medical dispute resolution before the MRD.

The MRD declined to order any additional payment for the services. Vista had the burden of proving that it is entitled to the additional payment it requests for the services rendered.[4] After considering all of the evidence and arguments, the ALJ concludes that Vista has failed to meet its burden; therefore, it is not entitled to any additional reimbursement in connection with those patients.

II. APPLICABLE LAW

Under the Texas Workers' Compensation Act (the Act),[5] 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

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[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 (Division). These cases arose before that transfer of authority.

[2] Because these cases were heard together and the issues are identical, the Administrative Law Judge (ALJ) is issuing this single decision.

[3] All of the above-referenced Respondents are related entities within the Travelers Insurance group of companies and are collectively referred to as Carrier.

[4] In medical dispute resolution cases, the burden of proof rests with the party seeking relief. 28 TEX. ADMIN. CODE § 148.14(a).

[5] TEX. LAB. CODE § 401.001, *et seq.*

compensable injury.[6]

The critical statutory provision applicable to the issues in the instant cases is § 413.011 of the Act. Section 413.011 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.[7] 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. 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.

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[6] TEX. LAB. CODE § 401.011(19) and (31). Unless otherwise noted, all citations to statutes and rules are to those in effect in 2001and early 2002 — during the relevant time periods in issue in these cases.

[7] In substance, the relevant language of § 413.011 is the same today as it existed in 2001 and 2002.

However, during all time periods relevant to these cases, the Commission had not established any payment guidelines for ASC services. Agency rules in effect in 2001 and 2002 provided:

> 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) [later codified at § 413.011], until such time that specific fee guidelines are established by the Commission.[8]

And:

> Ambulatory/outpatient surgical care . . . shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements.[9]

The applicable rules defined "fair and reasonable reimbursement" 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.[10]

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.

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[8] 28 TEX. ADMIN. CODE § 134.1(f).

[9] 28 TEX. ADMIN. CODE § 134.401(a)(4).

[10] 28 TEX. ADMIN. CODE § 133.1(a)(8).

III. DISCUSSION AND ANALYSIS

In each of the cases involved in this docket, the claimant sustained a work-related injury. The claimants all received care at a Vista ASC facility. Vista billed for its facility charges associated with the procedures performed by the treating physicians. In each case, Carrier paid a portion, but not all, of the billed charges. Vista sought additional reimbursement through the Commission's medical dispute resolution process. In all of the cases, the MRD denied further reimbursement, and Vista appealed.

For these 25 patients, Vista billed Carrier its usual and customary charges, ranging from a low of $5,143.06 to a high of $13,509.25, depending on the type of surgery and services provided. Carrier reimbursed amounts from $3,358.36 to $10,650.75. Vista seeks additional reimbursement that would provide it a total reimbursement equal to 70% of its billed charges in each case.

To support its request for additional reimbursement, Vista presented evidence of its billing practices and the amount of reimbursement it typically received from other insurance carriers and governmental bodies for the ASC services it provided during 2001. Vista argues that it is entitled to additional reimbursement because it historically received a level of reimbursement from other insurance companies and Medicare that is higher than that offered by Carrier in these cases. In particular, according to the data presented by Vista, its average reimbursement rate for ASC services was approximately 60% of billed charges. Further, its median reimbursement was 70% of billed charges. 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 cases.

Vista's evidence of its billing practices and what it typically received in reimbursement for its services fails to prove that the requested 70% constitutes a fair and reasonable reimbursement rate. Vista's case fails for several reasons. First, billed charges, discounted billed charges, and historical reimbursement rates do not, by themselves, 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. Historical rates of reimbursement say nothing about Vista's costs and profit margin, and therefore do not demonstrate

that Vista's requested rate of reimbursement is designed to ensure the quality of medical care while achieving effective medical cost control. Vista offered no evidence linking its 70% requested rate of reimbursement with statutory factors such as quality of care, cost control, increased security of payment, and amounts paid on behalf of non-workers' compensation patients with an equivalent standard of living.

In addition, Vista's evidence of its historical reimbursement rates is highly problematic. Vista offered a spreadsheet that purports to reflect the amounts billed by Vista and the amounts reimbursed by carriers for all CPT codes billed by Vista in connection with its patients in 2001.[11] The spreadsheet also purports to show what percent of the total billed amount was paid by the carrier in each instance. The spreadsheet provides the data underlying Vista's average and mean reimbursement numbers. However, the spreadsheet was prepared by persons who did not testify at the hearing, and the ALJ has no means of gauging the level of accuracy of the data included. Ms. Jean Wincher, a financial manager who testified on behalf of Vista, stated that she supervised the preparation of the spreadsheet, which was put together by other employees over the course of a month. While she testified that she had personally reviewed about 150-200 documents used in the creation of the spreadsheet (out of over 2,000 such documents), she did not otherwise describe any quality control measures in place in the compilation of the data.

Further, Ms. Wincher acknowledged that some of the explanations of benefits (EOBs) and medical records that included relevant data for the spreadsheet were unavailable because they had been destroyed in a flood. Ms. Wincher did not know which or how many such records were destroyed.

Even more problematic is Ms. Wincher's testimony that Vista billed different amounts for the same procedures, depending on who the payor was.[12] Because Medicare had a clear schedule for reimbursement, Vista often billed for Medicare patients according to the reimbursement schedule rather than based on Vista's costs. Ms. Wincher's testimony therefore indicates that the spreadsheet

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[11] Vista Exhibit 8.

[12] For example, the amounts billed to various carriers for CPT code 29819 (shoulder arthroscopy) ranged from $416.02 to $26,930.71.

data includes very high percentage rates of reimbursement for some patients because Vista had adjusted its billed amounts to match expected reimbursement. This practice by Vista, which resulted in a reimbursement rate of 100% for certain patients, has nothing to do with whether Vista's billing for other patients was fair and reasonable, yet the practice affected the average and mean reimbursement percentages on which Vista relies to show that it is entitled to 70% reimbursement across the board.

Finally, Ms. Wincher acknowledged that the spreadsheet includes a number of instances in which Vista was mistakenly reimbursed more than it billed for its ASC services. Because Vista's evidence includes these overpayments, the average reimbursement rate is inappropriately inflated by them.

Because Vista has failed to establish that a reimbursement rate of 70% of billed charges is fair and reasonable as defined by the applicable statute and rules, the ALJ concludes that Vista is entitled to no additional reimbursement in all of the cases in this proceeding. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

6. Each of the claimants involved in the 25 cases addressed by this order received care in 2001 or early 2002 at a Vista Healthcare, Inc., (Vista) ambulatory surgical center (ASC) facility for their compensable, work-related injuries.

7. Travelers Insurance (Travelers Indemnity Co. of Connecticut, Travelers Indemnity Company, Travelers Casualty & Surety Company of Illinois, Travelers Casualty & Surety Co., and Standard Fire Insurance Company)(Carrier) is the insurance carrier responsible for the workers' compensation insurance benefits administered to each of the claimants.

8. Vista billed Carrier its usual and customary charges for the services provided to each of the claimants, and Carrier reimbursed, as follows:

SOAH Docket No.	Amount Billed	Amount Paid
453-03-0563.M4	$5,867.51	$3,965.65
453-03-0565.M4	$5,916.85	$4,042.04
453-03-0566.M4	$7,583.60	$4,852.35
453-03-0567.M4	$11,135.06	$5,951.66
453-03-0569.M4	$6,594.57	$3,358.36
453-03-0570.M4	$10,118.24	$5,605.47
453-03-3095.M4	$5,579.07	$3,604.53
453-03-3691.M4	$5,143.06	$3,398.89
453-03-3692.M4	$12,299.69	$8,210.74
453-03-3693.M4	$6,003.81	$4,051.54
453-03-3694.M4	$10,621.84	$4,930.75
453-03-3696.M4	$8,914.67	$5,756.30
453-03-3697.M4	$5,717.32	$3,855.97
453-03-3698.M4	$5,322.06	$3,493.51
453-03-3904.M4	$7,350.96	$4,735.28
453-05-1511.M4	$5,847.78	$3,992.74
453-05-1512.M4	$5,837.74	$4,454.14
453-05-1514.M4	$5,459.40	$3,663.33
453-05-1515.M4	$13,328.45	$6,396.14
453-05-1518.M4	$10,272.28	$5,259.53
453-05-1519.M4	$13,509.25	$10,650.75
453-05-1520.M4	$6,074.65	$4,015.76
453-05-1526.M4	$6,917.07	$4,846.46
453-05-1530.M4	$10,244.13	$6,212.58
453-05-1463.M4	$11,639.22	$7,755.99

9. Vista sought additional reimbursement and submitted to the Texas Workers' Compensation Commission (Commission) a request for dispute resolution in each of the 25 dockets.

10. The Commission's Medical Review Division (MRD) issued its Findings and Decision in each of the dockets, ordering no additional reimbursement by Carrier. Vista requested a hearing in each of the 25 dockets.

11. The Commission issued timely notices of hearing and referred the cases to the State Office of Administrative Hearings (SOAH) for assignment of an Administrative Law Judge (ALJ) to hear the disputes.

12. 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.

13. On June 26, 2007, SOAH ALJ Carol S. Birch held a contested case hearing concerning the nine referenced dockets at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Vista appeared through its attorneys, Eric Carter and Christina Hernandez. Carrier appeared at the hearing through its attorney, Jack Latson. The record closed on July 27, 2007, after the parties had an opportunity to submit closing written arguments.

14. In each docket number in this proceeding, neither the amounts billed by Vista nor 70% of those amounts constitute fair and reasonable reimbursement for the services provided.

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 § 413.031.

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. TEX. LAB. CODE § 413.031; TEX. GOV'T CODE ch. 2003.

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

4. Adequate and timely notice of the hearing was provided. TEX. GOV'T CODE §§ 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 § 401.011(19) and (31).

6. In all of the 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 § 148.21(h).

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. The commission shall consider the increased security of payment afforded by the statute in establishing fee guidelines. TEX. LAB. CODE § 413.011.

8. During all time periods relevant to this case, there were no applicable payment guidelines established by the Commission for ASC services.

9. Reimbursement for services not identified in an established fee guideline shall be at fair and reasonable rates, as described in the Texas Workers' Compensation Act, Section 8.21(b) [later codified at § 413.011], until such time that specific guidelines are established. 28 TEX. ADMIN. CODE § 134.1(f).

10. Ambulatory/outpatient surgical care . . . shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements. 28 TEX. ADMIN. CODE § 134.401(a)(4).

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

ORDER

IT IS, THEREFORE, ORDERED that the Travelers Insurance group is not required to provide any additional reimbursement to Vista Healthcare, Inc.

SIGNED September 19, 2007.

CAROL S. BIRCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS