SOAH DOCKET NO. 453-03-3973.M4 – MDR Tracking No. M4-03-0253-01

SOAH DOCKET NO. 453-03-3974.M4 – MDR Tracking No. M4-03-0668-01

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

DECISION AND ORDER

I. INTRODUCTION

Vista Healthcare, Inc. (Vista) requested a hearing to contest two 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 Atlantic Mutual Insurance Company (Carrier) for services provided to two 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. Vista requested hearings in both dockets; because they involved the same issue, the two dockets were consolidated.

II. ISSUE AND BURDEN OF PROOF

In this docket, Prehearing Order No. 1 placed the burden of proving that its reimbursement methodology is fair and reasonable on Carrier.[2] If Carrier is successful, 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

[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.

[2] Carrier objected to this ruling. *See*, for example, Carrier's Rebuttal Closing Argument at pp. 1-6.

results.[3] 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.[4] Therefore, Vista is not entitled to any additional reimbursement.

III. APPLICABLE LAW

The Texas Workers' Compensation Act (the Act) is found at TEX. LAB. CODE ANN. § 401.001, *et seq.*[5] 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.[6]

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[3] 28 TAC § 133.1(a)(8), repealed effective May 1, 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.

[4] 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.

[5] 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.

[6] 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 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:

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.[7] 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.[8]

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

IV. DISCUSSION AND ANALYSIS

In each of the two 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' charges are not in dispute in this proceeding, nor is there a dispute about the medical necessity of the treatments rendered. Rather, the parties' dispute arises from the amount Vista billed for its facility charges. Vista seeks reimbursement of 70% of its billed charges, amounts beyond those which the MRD ordered.

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

[7] 28 TAC § 134.1(f), repealed effective May 1, 2006. 31 Tex. Reg. 3560 (2006).

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

In each docket, Vista billed Carrier what it alleges were its usual and customary charges, with the charges in 453-03-3973.M4 being $6,296.17 and the charges in 453-03-3974.M4 being $6,248.77. Carrier reimbursed Vista $3,090.50 in 453-03-3973.M4 and $4,049.82 in 453-03-3974.M4.[9] Through the testimony of its expert witness Nicholas Tsourmas, M.D.,[10] Carrier showed that its reimbursements to Vista in each docket approximately tripled 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 Fee Guidelines 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 Fee Guidelines 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 two 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 four to six 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

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[9] Carrier Ex. 3.

[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).

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 firm, and acted as Vista's supervisor of 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 only about 60% of its billed charges. 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. While the ALJ accepts that Ms. Wincher is a person experienced in billing and collecting ASC charges, he cannot accept her testimony that Vista was reimbursed at 70% of its charges when Vista's own partial documented billing history suggests that the actual amounts pad Vista were 60%, not 70%, of billed charges. In addition, 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 average reimbursement rate. Finally, it would be a stretch to find that Vista's billing methodology produced fair and reasonable charges when its own evidence suggests that it received on average only 60% of those charges.

Another issue also leads to the conclusion that Carrier met its burden of proof, while Vista did not. Vista's 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. Vista showed that Carrier reimbursed it at amounts ranging from 28% to 78% of its billed charges,[13] and argues that Carrier did not apply its reimbursement methodology consistently, as required by prior Commission rule 133.304.[14] But the issue for this hearing is not compliance with Rule 133.304; it is fair and reasonable reimbursement. Thus, the ALJ concludes that Carrier's methodology complies with the factors identified in Section 413.011, and makes the following findings of fact and conclusions of law.[15]

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. 453-03-3973.M4 and 453-03-3974.M4.

2. On September 28, 2001, Claimant in 453-03-3973.M4 received cervical facet injections, bilaterally, to C3 through C6, a fluoroscopy, and radiological examination of the cervical spine and interpretation. The services were rendered for treatment of a compensable injury.

3. On October 31, 2001, Claimant in 453-03-3974.M4 received bilateral lumbar facet injections to L3 through S-1, a fluoroscopy, and radiological examination of the cervical spine, and interpretation. The services were rendered for treatment of a compensable injury.

4. Each of the claimants involved in the two dockets addressed by this Decision and Order received care at a Vista ambulatory surgical center facility (ASC) for his or her compensable, work-related injury.

5. Vista billed Carrier for services provided to each of the two claimants, with the charges in Docket No. 453-03-3973.M4 being $6,296.17 and the charges in Docket No. 453-03-3974.M4 being $6,248.77.

6. Carrier reimbursed Vista $3,090.50 in 453-03-3973.M4 and $4,049.82 in 453-03-3974.M4.

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

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[13] Vista Ex. 8.

[14] 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).

[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.

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

9. 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.

10. 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.

11. On July 19, 2007, SOAH Administrative Law Judge Charles Homer III held a contested case hearing concerning the two 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.

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

13. Medicare Fee Guidelines 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.

14. 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.

15. Payments by Carrier to Vista in each of the underlying dockets approximately quintupled the fee guidelines for ambulatory surgical centers amount ($725.22) that is based on Medicare Fee Guidelines for the services performed for Claimants at ambulatory surgical centers.

16. 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. § 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 in issue 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 two dockets in this proceeding, Carrier had the burden of proving by a preponderance of the evidence that its reimbursement methodology was fair and reasonable. TEX. LAB. CODE ANN. § 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. The commission shall consider the increased security of payment afforded by this subtitle in establishing fee guidelines. TEX. LAB. CODE ANN. § 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. 28 TAC § 133.1(a)(8), repealed effective May 1, 2006. 31 Tex. Reg. 3543 (2006).

9. Based on Findings of Fact Nos. 6, 12, 13, 14, and 15, Carrier established that its reimbursements in each docket are fair and reasonable.

ORDER

Carrier's reimbursements to Vista are fair and reasonable for the disputed charge in each docket. **IT IS, THEREFORE, ORDERED** that Atlantic Mutual Insurance Company is not required to pay any additional reimbursement for the services in issue in the two dockets in this proceeding.

SIGNED September 20, 2007.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS