SOAH DOCKET NO. 453-04-3607.M4
TWCC CASE NO. 03-7811

TEXAS MUTUAL INSURANCE COMPANY, **Petitioner**	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
HOUSTON PREMIER DME, **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Texas Mutual Insurance Company (ACarrier@) has challenged a decision of the Texas Workers' Compensation Commission's Medical Review Division (AMRD@), which mandated additional reimbursement to Houston Premier DME (AProvider@) for durable medical equipment provided to a claimant suffering from a compensable injury.

This decision disagrees with that of the MRD, concluding that Provider is entitled to no further reimbursement, since the amount already paid by Carrier is fair and reasonable for the equipment at issue.

II. JURISDICTION, NOTICE, AND VENUE

The Texas Workers' Compensation Commission (ACommission@) has jurisdiction over this matter pursuant to ' 413.031 of the Act. The State Office of Administrative Hearings (ASOAH@) has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to ' 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003. No party challenged jurisdiction, notice, or venue.

III. STATEMENT OF THE CASE

The hearing in this docket was convened on August 30, 2004, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (ALJ) Mike Rogan presided. Carrier was represented by Katie Kidd, attorney. Provider was represented by Patricia Serna, who appeared by telephone. Both parties presented evidence and argument. The record was left open to allow submission of additional briefing and documentation and closed on September 13, 2004.[1]

The record revealed that on June 17, 2002, Provider supplied a bone growth stimulator (BGS)to a claimant suffering from a compensable injury. When Provider subsequently sought reimbursement of $5,900.00 for this equipment, however, Carrier (the insurer for the claimant's employer) refused to recognize the full amount billed as fair and reasonable. Instead, Carrier ultimately offered payment of $3,509.76 B including $145.41 remitted some time after the initial payment.[2] Provider sought medical dispute resolution through the MRD, which issued a decision on January 13, 2004, concluding that Provider had established its full charges for the disputed equipment as a fair and reasonable rate of reimbursement.

The MRD decision noted that Provider had supported its position by submitting copies of a number of Explanations of Benefits (EOBs), showing that other carriers had accepted Provider's billing for the item of equipment in dispute, while Carrier had merely catalogued three instances in which it had made reimbursement for such equipment at lower rates. The MRD thus concluded that Provider had more convincingly demonstrated its satisfaction of Commission Rule 133.307(g)(3)(D), which requires documentation in medical fee disputes to include the following:

[1] The staff of the Commission formally elected not to participate in this proceeding, although it filed a general Statement of Matters Asserted with the notice of the hearing.

[2] Carrier apparently made its original reimbursement based upon a 2001 Medicare Fee Schedule and later remitted the additional $145.41 in order to be consistent with the applicable 2002 fee schedule.

> If the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with ' 133.1 of this title (relating to Definitions) and ' 134.1 of this title (relating to Use of the Fee Guidelines).

Based on this rationale, the MRD ordered Carrier to reimburse Provider the full amount billed for the BGS B *i.e.*, $2,535.65 more than Carrier had initially paid Provider. Carrier then made a timely request for review of the MRD decision before SOAH.

IV. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Carrier

Carrier contends that it has established a methodology for determining fair and reasonable reimbursement levels in cases of this type B *i.e.*, employing the Medicare Fee Schedule applicable to Texas (as reflected in the 2002 Region C DMEPOS Fee Schedule published by Palmetto GBA, which is the regional carrier that administers the processing of Medicare claims for DME within the region). According to the 2002 fee schedule, the proper reimbursement for a new BGS (coded as E0747) is $3,509.76.

Ron Nesbitt, a dispute analyst for Carrier, testified that the company B as required by 28 TAC ' 133.304(I)(1) B has applied this methodology for determining reimbursement consistently. In 2002, Carrier received 52 requests to reimburse various care providers for BGSs, and in 25 of those instances, the company reimbursed those claims at $3,509.76. (In a number of those cases, Mr. Nesbitt added, Carrier refused any reimbursement or, for various reasons, reimbursed at lower levels, and in a few cases, it erroneously reimbursed at higher levels.)

B. Provider

Provider urged that the MRD in this case had properly found a survey of EOBs from Provider's geographical area to be an appropriate way of determining a fair and reasonable reimbursement for the type of equipment at issue. Provider submitted to the MRD billing and payment documentation showing that, during 2002, at least seven insurers within the region had reimbursed Provider $5,900.00 per unit for the type of equipment at issue in this case.

According to the testimony of Lily Mendoza, Provider's supervisor for billing and collection, the billing in this case represented the Provider's usual and customary rate for a new BGS. Ms. Mendoza also stated that Provider had billed Carrier at this rate for nine separate BGSs during 2002, while Carrier's actual reimbursements in the cases had reflected four different levels, varying from $3,465.00 to $5, 494.50. Provider concluded, therefore, that Carrier in fact has been inconsistent in determining appropriate reimbursement for the type of equipment at issue in this case.

V. ANALYSIS

Where, as in this case, the medical equipment at issue is subject to neither a negotiated contract rate of reimbursement nor a maximum allowable reimbursement set by an applicable Commission fee guideline, payment for such equipment must be Afair and reasonable@ under more general regulatory criteria. The applicable definition for Afair and reasonable reimbursement,@ in Commission Rule 133.1(a)(8), is the following:

> Reimbursement that meets the standards set out in ' 413.011 of the [Act], and the lesser of a health care provider's usual and customary charge, or
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> . . . (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 . . .

Although ' 413.011 of the Act actually sets standards for the Commission's adoption of fee and treatment *guidelines*, such standards logically can be extrapolated, in large part, to the evaluation of individual reimbursements by insurers, as well. Subsection (d) of the statute enumerates the criteria most clearly germane to determining whether reimbursements are fair and reasonable; it states:

> 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 the fee guidelines.

As noted by Mr. Nesbitt in this case, the Commission has determined that the populations served by Medicare and by the Texas workers' compensation system have equivalent standards of living B a conclusion expressed in the 1997 preamble to the Commission's guidelines for acute-care in-patient hospital fees, as adopted in the *Texas Register*.[3] That preamble also stated the following:

> . . . [T]he Commission believes that Medicare rates are fair and reasonable payment for Medicare patients, and ensure Medicare patients access to quality health care. The Medicare fee program is also designed to achieve effective cost control . . .[4]

Logically, if Medicare rates offer quality care and effective cost control for Medicare patients, they do the same for other patients with an equivalent standard of living. In the ALJ's view, thus, the cited preamble constitutes an official declaration by the Commission that a reimbursement consistent with Medicare fee schedules satisfies most of the criteria for Afair and reasonable@ reimbursement, as set out in Commission Rule 133.1(a)(8) and in ' 413.011(d) of the Act.[5] In addition, testimony

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[3] 22 *TexReg.* 6264, 6284 (July 4, 1997).

[4] *Id.*, at 6283.

[5] The Commission's preamble statement does not address all such regulatory criteria; notably, it does not state or directly imply that Medicare rates are consistent with rates that would be paid by a person with an equivalent standard of living *if such a person was taking direct responsibility for the payment* B which is one of the elements for evaluating Afair and reasonable@ reimbursement under ' 413,011(d) of the Act.

presented by Carrier indicated that it at least makes a reasonable effort to apply consistently its Medicare-fee-schedule based method for determining reimbursement.

On the other hand, Provider presented no evidence at all that the reimbursement it sought in this case (its usual and customary charge for a BGS) satisfied any of the regulatory criteria for fair and reasonable reimbursement. The fact that some insurers have been willing, at times, to pay the Provider's billed rate for a BGS does not by itself demonstrate, as far as the ALJ can discern, that such a level of reimbursement ensures access to quality health care, is designed to achieve effective cost control, is consistent with fees charged for similar treatment of an injured individual of an equivalent standard of living that are paid by that individual, or fulfills any of the other applicable criteria.

VI. CONCLUSION

The ALJ finds that, under the rather marginally developed record provided in this case, Carrier has demonstrated by a preponderance of evidence that its level of reimbursement for the disputed BGS was fair and reasonable, while Provider has failed to present any such evidence with respect to the higher level of reimbursement it seeks. Contrary to the conclusion of the IRO in this case, therefore, reimbursement to the Provider of more than the $3,509.76 already paid by Carrier for the BGS is not appropriate.

VII. FINDINGS OF FACT

1. On June 17, 2002, Houston Premier DME (AProvider@) supplied a bone growth stimulator (ABGS@) to a claimant suffering from a compensable injury under the Texas Worker's Compensation Act (Athe Act@), TEX. LABOR CODE ANN. ' 401.001 *et seq.*

2. Provider sought reimbursement of $5,900.00 for the equipment noted in Finding of Fact No. 1 from the insurer for the claimant's employer, Texas Mutual Insurance Company ("Carrier"). In response, Carrier declined to recognize Provider's charge as "fair and reasonable" and ultimately offered payment of $3,509.76 - including $145.41 remitted some time after the initial payment.

3. Provider made a timely request to the Texas Workers' Compensation Commission ("Commission") for medical dispute resolution with respect to the requested reimbursement.

4. The Commission's Medical Review Division ("MRD") reviewed the dispute and concluded, in a decision dated January 13, 2004, (in dispute resolution docket No. M4-03-7811-01) that Provider had established its full charges for the disputed equipment ($5,900.00) as a fair and reasonable rate of reimbursement.

5. Carrier requested in timely manner a hearing with the State Office of Administrative Hearings ("SOAH"), seeking review and reversal of the MRD decision regarding reimbursement.

6. The Commission mailed notice of the hearing's setting (originally for April 9, 2004) to the parties at their addresses on March 3, 2004. The hearing was subsequently continued to August 30, 2004, with proper notice to parties.

7. A hearing in this matter was convened on August 30, 2004, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Mike Rogan, an Administrative Law Judge with SOAH. Provider and Carrier were represented.

8. The record in this administrative proceeding remained open until September 13, 2004, to allow the parties to submit argument and documentation.

9. Under Commission rules or guidelines, no maximum allowable rate for a BGS existed in 2002; reimbursement for such items was limited to fair and reasonable rates, consistent with ' 413.011 of the Act and 28 TEX. ADMIN. CODE §§ 133.1(a)(8) and 134.1.

10. No contractual agreement for billing or reimbursement of BGSs existed during 2002 between Provider and Carrier.

11. Carrier determined that $3,509.76 was the fair and reasonable reimbursement level for the disputed BGS (coded as E0747) by employing the Medicare Fee Schedule applicable to Texas (as reflected in the 2002 Region C DMEPOS Fee Schedule published by Palmetto GBA, the regional carrier that administers the processing of Medicare claims for DME within the region).

12. In general, during 2002, Carrier uniformly applied the method of determining the fair and reasonable reimbursement level for BGSs, as noted in Finding of Fact No. 11, despite a few instances in which Carrier erroneously reimbursed health care providers at higher levels.

13. Provider determined that $5,900.00 B its usual and customary rate for a BGS during 2002 B was a fair and reasonable reimbursement level for such equipment by surveying explanations of benefits and observing that , during 2002, at least seven insurers within its geographical

region had reimbursed Provider $5,900.00 per unit for such equipment

VIII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. ' 413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to ' 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. ADMIN. CODE ("TAC") § 133.305(g) and §§148.001-148.028.

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

5. Carrier, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.21(h).

6. The Commission has determined that a reimbursement consistent with Medicare fee schedules generally satisfies the criteria for "fair and reasonable" reimbursement, as set out in 28 TAC §§ 133.1(a)(8) and 134.1 and in §413.011(d) of the Act B which include ensuring access to quality health care, offering effective cost control, and maintaining consistency with fees charged for similar treatment of an injured individual of an equivalent standard of living. 22 *TexReg* 6264, 6284 (July 4, 1997).

7. Based upon the foregoing Findings of Fact and Conclusions of Law, Carrier has demonstrated by a preponderance of the evidence that its reimbursement of Provider in this case generally satisfies the applicable regulatory criteria for fair and reasonable reimbursement for the type of equipment noted in Finding of Fact No. 1.

8. Based upon Finding of Fact No. 12, Carrier during 2002 consistently applied the methodology by which it determined fair and reasonable reimbursement for the type of equipment noted in Finding of Fact No. 1, as required by 28 TAC §133.304(I)(1).

9. Provider's demonstration of a sampling of payments by several other carriers was, by itself, insufficient to show that Provider's usual and customary charge for the equipment noted in

Finding of Fact No. 1 met the criteria for fair and reasonable reimbursement.

10. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decision of the MRD issued on January 13, 2004, were incorrect; rather, reimbursement to the Provider of more than the $3,509.76 already paid by Carrier for the BGS noted in Finding of Fact No. 1 is not appropriate.

ORDER

IT IS THEREFORE ORDERED that, based upon Texas Mutual Insurance Company's successful challenge of an MRD decision dated January 13, 2004, Texas Mutual Insurance Company is not required to make further reimbursement (beyond the $3,509.76 already paid by the company) to Houston Premier DME for a bone growth stimulator supplied to a claimant on June 17, 2002.

SIGNED November 1, 2004.

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MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS