SOAH DOCKET NO. 454-11-5860.M4
DWC NO. M4-04-3967-01

VISTA MEDICAL CENTER HOSPITAL,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
SERVICE LLOYDS INSURANCE CO.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Vista Medical Center Hospital (Vista) challenges the denial of additional reimbursement by Service Lloyds Insurance Company, (Service Lloyds) for among other procedures, an arthroscopic subacromial decompression of the right shoulder on December 12, 2002, at Vista's hospital outpatient facility (HOP) and billed under CPT Code 29826. Vista billed $61,825.94 for the surgery, and Service Lloyds reimbursed Vista in the amount of $4,472.00. The Administrative Law Judge (ALJ) finds that Vista failed to prove it was entitled to additional reimbursement. Accordingly, its request for additional reimbursement is denied.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no issues of notice or jurisdiction. Therefore, these matters are addressed in the Findings of Fact and Conclusions of Law without further discussion.

Vista filed a request for medical fee dispute resolution with the Medical Review Division (MRD) of the Texas Department of Insurance, Division of Workers' Compensation (Division).[1] The Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision), denying Vista additional reimbursement. Vista timely requested a hearing before the State Office of

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[1] Effective September 1, 2005, the legislature dissolved the Texas Workers' Compensation Commission (Commission) and created the Division of Workers' Compensation within the Texas Department of Insurance. Act of June 1, 2005, 79th Leg., R.S., ch. 265, § 8.001, 2005 Tex. Gen. Laws 469, 607. This Decision and Order refers to the Commission and its successor collectively as the Division.

Administrative Hearings (SOAH) to contest MRD's determination. A hearing convened before ALJ Gary Elkins on May 9, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Christina Y. Hernandez. Service Lloyds was represented by attorney Roy Horton. The record closed on August 24, 2012, following the filing of post-hearing briefs.

II. DISCUSSION

A. Applicable Law

This case is governed by the Tex. Lab. Code (Labor Code) § 401.001*et seq.*, also known as the Texas Workers' Compensation Act (Act). The workers' compensation insurance program created by the Act covers all medically necessary health care.[2] Although amended several times, Section 413.011 of the Act generally directs the Division's Commissioner to 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.[3] The Act has consistently required that the fee guidelines for medical services be fair and reasonable, ensure quality medical care, and achieve effective medical cost control.[4] 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.[5] In setting such guidelines, the increased security of payment afforded by the Act also must be considered.[6]

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[2] Tex. Lab. Code § 401.011.

[3] This section of the Act has been amended on several occasions as follows:

> Acts 1993, 73rd Leg. ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 2001, 77th Leg., ch. 1456, Sec. 6.02, eff. Jun. 17, 2001; Acts 2003, 78th Leg., ch. 962, Sec. 1, 2, eff. Jun. 20, 2003.
> Amended by:
> Acts 2005, 79th Leg., ch. 265, Sec. 3.233, eff. Sept. 1, 2005.
> Acts 2007, 80th Leg. R.S., ch. 1177, Sec. 2, eff. Sept. 1, 2007.
> Acts 2007, 80th Leg., R.S. ch. 1177, Sec. 2, eff. Jan. 1, 2011.

[4] Tex. Lab. Code § 413.011(d).

[5] Tex. Lab. Code § 413.011(d).

[6] Tex. Lab. Code § 413.011(d).

Prior to March 2008, the Division did not have a fee guideline for HOP services.[7] In reimbursing providers for services without a fee guideline, an insurance carrier is required to reimburse at a fair and reasonable rate, as described in Section 413.011(d) of the Act.[8] Until May 2006, "fair and reasonable reimbursement" was defined as follows:

> 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.[9]

Effective May 2, 2006, the Division defined "fair and reasonable reimbursement" as reimbursement that:

> (1) is consistent with the criteria of Labor Code § 413.011;
> (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and
> (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.[10]

When the Division has not established a fee guideline for a particular procedure, service, or item, the Division's rules require carriers to develop and consistently apply a methodology to determine fair and reasonable reimbursement.[11]

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[7] Effective March 1, 2008, the Division adopted a fee guideline for outpatient medical services28 Tex. Admin. Code (TAC) § 134.403. By its terms, that fee guideline applies only to outpatient medical services provided on or after March 1, 2008.

[8] 28 TAC § 134.1(f) from Oct. 7, 1991 until May 16, 2002, when it became 28 TAC § 134.1(c). On May 2, 2006, it became 28 TAC § 134.1(c)(3). On March 1, 2008 it was amended to become 28 TAC § 134.1(e)(3).

[9] 28 TAC § 133.1(8).

[10] 28 TAC § 134.1(d)(1)-(3). Amended in 2008 to 28 TAC § 134.1(f)(1)-(3).

[11] 28 TAC § 133.304(i)(1) (eff. July 15, 2000); 28 TAC § 134.1(e) (eff. May 2, 2006).

B. Evidence

1. Vista

Jacquelyn Pham, Director of Business Financial Services for Doctors Practice Management,[12] testified on behalf of Vista regarding its billings and collections process. She explained that Vista requests reimbursement in an amount within a range of payments received for the same services by different carriers based on the following:

- a review of the history of payments received by Vista in 2002 and 2003 from various carriers;
- the average of the reimbursements received from various carriers in 2002 and 2003 for the procedures performed; and
- recent decisions by the Division issued in cases involving Renaissance Hospital.

In 2002, the reimbursements averaged $9,737.69 for CPT Code 29826. If the claims that are the subject of a fee dispute between Vista and a carrier are excluded from the average, then the reimbursement from carriers averaged $35,638.80. In 2003, the average reimbursements were $13,772.92 and $11,954.80, respectively. Ms. Pham testified that Vista seeks the average payment made in cases that were not subject to a fee dispute because including those claims where the amount of reimbursement is still in dispute would unfairly skew the average. Consequently, Vista asserts, it seeks additional reimbursement within a range of the two averages.

In the alternative, Vista seeks the average payment made by all workers' compensation carriers for the procedures billed, in line with the analysis made in the Renaissance cases and based on Commissioner's Bulletin #B-009-07 and a March 2005 MDR Newsletter. Based on these authorities, additional reimbursement within a range of the two averages should be awarded. Vista pointed out that, in the Renaissance cases, the Division found that Renaissance had demonstrated that the average amount paid by all insurance carriers in the Texas workers' compensation system

[12] Doctors Practice Management handles the billing and collection functions for Vista.

during the same year and involving the same principal diagnosis and procedure codes was a fair and reasonable rate of reimbursement. Thus, its reliance on the Renaissance cases was well-founded as the most recent and thorough analysis by MRD of what constitutes a fair and reasonable reimbursement. Vista observes that, despite the payment analysis in the Renaissance cases, it has been unable to apply the principal diagnosis and procedure code data to its cases because Vista's services are identified by CPT code and not by the data produced in the Renaissance cases.

Vista argues that Service Lloyds did not present any testimony at the hearing and that the development and application of its payment methodology pursuant to the requisite fair and reasonable reimbursement standard is unknown. It added that Service Lloyds also did not present any evidence that discusses or explains how the amount it reimbursed in this case represented a fair and reasonable reimbursement. Nor did it submit nationally recognized public studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to demonstrate that the amount of reimbursement was fair and reasonable. Instead, Service Lloyds submitted an alternative theory of fair and reasonable reimbursement that calculated reimbursement amounts under the current hospital outpatient fee guideline that do not apply to the dates of service at issue. Thus, Vista argues, Service Lloyds failed to establish that its methodology yielded a fair and reasonable reimbursement.

Vista requested that, in the event its average payment analysis is rejected, Service Lloyds' alternative theory of what constitutes a fair and reasonable reimbursement should be considered, and Service Lloyds should be ordered to pay an amount that represents the difference in the calculation of the current fee guideline and amounts it already paid.

2. Service Lloyds

Service Lloyds' arguments in response to Vista's theory of recovery include following:

- Vista had the burden of proving, first, that the amount paid by Service Lloyds is not reasonable, and second, that the amount it seeks is fair and reasonable, but failed to do either.

- The version of Tex. Lab. Code § 413.011 in effect at the time of Claimant's injury required that the Division adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modification to those reimbursement methodologies as necessary to meet occupational injury requirements. Medicare is clearly the standard baseline by which a fee reimbursement structure is to be measured.

- Section 413.011(d) requires that fee guidelines be fair and reasonable and designed to ensure quality medical care and to achieve medical cost control, and they 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.

- Vista argues against the Medicare rate, or even 200 percent of it, even though the Division has found that Medicare patients and workers' compensation patients have equivalent standards of living.

- The Division has adopted a $1,118 maximum per diem rate for inpatient surgical hospitalizations, and hospital outpatient procedures are analogous to inpatient procedures.

- In this case Service Lloyds' methodology required a payment of $2,236, amounting to 200 percent of the per diem rate, plus $396 for surgical implants at cost plus 10 percent. (Service Lloyds noted that the reimbursement of $4,472 reflects that it may have inadvertently double-reimbursed Vista on this claim.)

- Vista presented no evidence on how it arrived at its usual and customary billing numbers.

C. Analysis and Conclusion

Vista's theory of recovery was not consistent with the Division's decisions in the two Renaissance cases.[13] Furthermore, Vista failed to establish how its requested reimbursement level of $9,737.69 to $35,638.80 for CPT Code 29826 complied with criteria contained in the Act and the Division's rules for fair and reasonable reimbursement. Because Vista did not meet its burden of proof, it is not entitled to additional reimbursement from Service Lloyds.

III. FINDINGS OF FACT

1. On December 12, 2002, Vista Medical Center Hospital (Vista) provided an arthroscopic subacromial decompression of the right shoulder to a workers' compensation claimant at its hospital outpatient facility (HOP) and billed under CPT Code 29826

2. Service Lloyds Insurance Company (Service Lloyds) was the responsible workers' compensation insurer for the claimant.

3. Vista billed Service Lloyds $61,825.94 for the shoulder surgery.

4. Service Lloyds reimbursed Vista $4,472.00 for the shoulder surgery.

5. Vista requested additional reimbursement, which Service Lloyds denied.

6. Vista timely filed a request for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division).

7. On April 26, 2011, the Division's Medical Review Division (MRD) issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision), finding that no additional reimbursement was owed to Vista.

8. Vista timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the MRD Decision.

9. A Notice of Hearing informed the parties of the date, time, and location of the hearing; the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

10. A hearing convened before Administrative Law Judge Gary Elkins on May 9, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Christina Hernandez.

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[13] The ALJ offers no opinion and makes no decision on whether the methodology used in the Renaissance cases is valid for determining fair and reasonable reimbursement.

Service Lloyds was represented by attorney Roy Horton. The record closed on August 24, 2012, following the filing of closing briefs.

11. At the time Vista provided the services, there was no fee guideline for HOP services.

12. Vista failed to prove that using an average range of payments of $9,737.69 to $35,638.80 for CPT Code 29826 constituted fair and reasonable reimbursement based upon the applicable criteria.

IV. CONCLUSIONS OF LAW

1. 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 § 413.031 and Tex. Gov't Code ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Tex. Gov't Code §§ 2001.051 and 2001.052.

3. The services provided to the Claimant were not covered by a fee guideline issued by the Division, so they were required to be billed and reimbursed at a fair and reasonable rate, within the meaning of Tex. Lab. Code § 413.011.

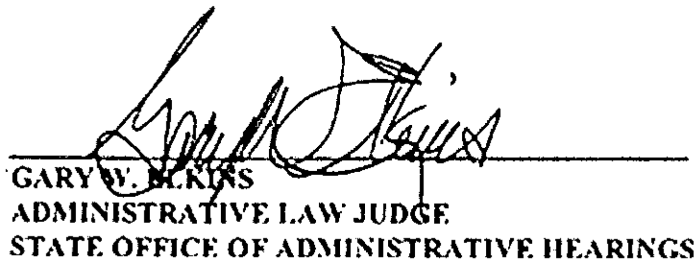
4. Vista failed to prove the reimbursement it requested was fair and reasonable.

5. Vista is not entitled to additional reimbursement from Service Lloyds for the services provided to the claimant.

ORDER

IT IS ORDERED that Vista is not entitled to additional reimbursement for the services provided to the Claimant.

SIGNED October 23, 2012.



GARY W. ELKINS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS