SOAH DOCKET NO. 454-12-4924.M4
MDR NO. M4-08-1407-01 and -02

OLD REPUBLIC INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
V.	§	
	§	
RENAISSANCE HOSPITALS,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

This is one of four cases heard together because they involve the same basic legal issues and evidence.[1] Each case involves services rendered by Renaissance Hospitals (Renaissance) to an injured employee covered by the workers' compensation insurance system. Each case involves a separate insurance carrier, but the same attorney represented the insurance carriers in the hearing.

In each case, the Texas Department of Insurance's Division of Workers' Compensation (Division)[2] conducted medical dispute resolution (MDR) and ordered the insurance carrier to make additional reimbursement to Renaissance. These additional reimbursements range from a high of $2,306.64 to a low of $610.13. In this particular case, the additional amount ordered was $2,190.29. In reaching its decision, the Division relied on a system-wide (*i.e.*, statewide) average payment method proposed by Renaissance—namely, the overall statewide average amount paid by all insurance carriers to all providers for the particular procedure. The Division determined that using the average of system-wide payments would result in a fair and reasonable reimbursement. In each

[1] The other cases are SOAH Docket Nos. 454-12-4925; 454-12-5454; and 454-12-5501.

[2] 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.

case, the insurance carrier was dissatisfied with the outcome and requested a hearing. This case involves Old Republic Insurance Company (Carrier) as the workers' compensation insurance carrier.

The issue to be addressed involves the determination of a fair and reasonable reimbursement for outpatient services in each of the cases in issue.[3] After considering all of the evidence and arguments, the Administrative Law Judges (ALJs) conclude that the evidence is insufficient to allow the ALJs to make an appropriate determination of a fair and reasonable reimbursement for the services in issue. Therefore, no party is entitled to relief in this docket and the underlying MDR determinations shall govern.

II. APPLICABLE LAW

At the outset of this decision, it is appropriate to set forth the legal backdrop for the workers' compensation reimbursement system. 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 return to or retain employment.[4]

Section 413.011 of the Act provides that the Division 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 fee guidelines must be fair and reasonable

[3] The parties' dispute centers on the methodology of determining fair and reasonable reimbursements in general for a variety of outpatient services, so the particular services themselves are not pertinent for discussion.

[4] Tex. Lab. Code § 401.011(19) and (31). The Texas Workers' Compensation Act is found at Tex. Lab. Code § 401.001 *et seq.* and is hereafter referred to as "the Act."

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.

Where the Division has not established a fee guideline and where no negotiated contract exists, an insurance carrier shall reimburse at fair and reasonable rates as described in Section 413.011(d).[6] Therefore, when, as in the present case, the Division 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 Division 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 Division in setting fee guidelines.

III. DISCUSSION

A. Burden of Proof

The parties vigorously disagree over who has the burden of proof. Both parties cite to the Division's burden of proof rule, currently found at 28 Tex. Admin. Code § 148.14, which states the burden of proof "rests with the party seeking relief." Because this is a procedural rule that has not been adopted by the State Office of Administrative Hearings (SOAH), it is not binding.[7] It does, however, reflect agency rules and policy that SOAH ALJs consider when determining how to apply the burden of proof in a given case.[8] Moreover, SOAH's rules set out additional factors to consider

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[5] Act § 413.011(d).

[6] Currently 28 Tex. Admin. Code § 134.1(e)(3) and (f). From May 16, 2002, to May 2, 2006, 28 TAC § 134.1(c). From May 2, 2006 to March 2008, 28 Tex. Admin. Code § 134.1(c)(3) and (d).

[7] Tex. Gov't Code § 2003.050(b).

[8] 1 Tex. Admin. Code § 155.427.

when determining burden of proof.[9] It is within this legal framework that the ALJs analyze this case.

Carrier asserts that Renaissance requested MDR and had the burden of proving its entitlement to additional reimbursement at the Division. Because the SOAH hearing is *de novo*, Carrier argues that Renaissance continues to bear that burden of proof to show it is entitled to additional reimbursement. Carrier argues that Renaissance is the party seeking relief, because it is the party seeking additional payment.

In contrast, Renaissance notes that it prevailed through MDR and there currently is an order requiring Carrier to make additional reimbursement. It is from this order that Carrier sought a hearing. Therefore, because Carrier requested the hearing before SOAH, Renaissance argues that Carrier has the burden of proof. Specifically, Renaissance contends that Carrier is the party seeking relief, because it requested the hearing "seeking relief" from the MDR order requiring additional payment.

The ALJs conclude at the outset that the purpose of this docket is not to review the amounts ordered through MDR. Rather, SOAH hearings have historically involved a *de novo* review of the issues involved, and have not been simply a review of the propriety of the MDR decision. Contrary to Carrier's assertion that the *de novo* nature of these hearings is set out in chapter 2001 of the Texas Government Code,[10] the *de novo* nature of SOAH hearings is not the result of specific statutes, applicable procedural rules, or case law requiring it. Rather, it has developed through past SOAH precedent—the same precedent which has, for more than 10 years, almost uniformly placed the burden of proof on the party requesting the SOAH hearing in medical fee dispute cases. In part, this comes from the recognition that the party requesting the SOAH hearing is the party seeking to change the status quo.

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[9] 1 Tex. Admin. Code § 155.427.

[10] The only *de novo* standard discussed in chapter 2001 of the Government Code relates to judicial challenges of SOAH or other agency decisions. Nowhere in chapter 2001 are SOAH hearings established as *de novo* proceedings.

Carrier argues that there is no status quo once it requests a SOAH hearing—because the MDR decision is allegedly vacated at that point. However, this is not accurate. SOAH cases are routinely dismissed for various reasons and, in such cases, it is recognized that the MDR decision remains in effect in the absence of an order from SOAH specifically superseding it.[11] Moreover, requiring providers to bear the burden of proof again at SOAH in situations where the Division ordered the carrier to pay additional reimbursement would essentially nullify the entire MDR process.

In medical fee disputes, it is the healthcare provider who generally initiates the proceeding by filing a request for additional payment from the insurance carrier. Thus, if the MDR decision is of no consequence whatsoever, and the provider must prove its case again in a SOAH hearing, this would give an unfair procedural advantage to carriers by making providers first attempt to gain payment from the carrier, then attempt to gain payment through the MDR process, and then again attempt to gain payment through the SOAH hearing process. Insurance carriers could choose to deny each step along the way with little or no reason to engage in legitimate good-faith efforts to resolve the dispute, but requiring providers to exert considerable effort to get additional payment.

To give meaning to the rules and purposes behind the MDR process, SOAH ALJs have historically seen the MDR process as having three significant impacts: (1) it defines the scope of the dispute; (2) it limits the claims or defenses that may be raised; and (3) it sets the burden of proof in the SOAH proceeding. So, while the ALJs agree that this is a *de novo* proceeding, they only mean that the SOAH hearing is the proceeding of record (*i.e.*, where the evidentiary record is established) and, accordingly, the parties may present new evidence at the hearing not previously considered in MDR. However, the parties' claims and defenses are limited to those properly raised previously in MDR, and the status quo in the absence of a SOAH decision superseding it is the MDR order. The

[11] In fact, if Carrier was correct that the MDR decision is vacated upon the request for a SOAH hearing, then Carrier could simply request a hearing and then move to dismiss the case/withdraw its request before the hearing was conducted. In such a scenario, under Carrier's argument there would be no existing MDR order by which it would be bound. This is not a tenable position under the law.

ALJs find it appropriate to place the burden of proof—as has been done historically in SOAH hearings over the last decade—on the party requesting relief from the MDR decision. In this case, that is the Carrier.

B. ALJs' Analysis

With that in mind, the ALJs now turn to the issue they believe must be addressed in this case. Essentially, the ALJs must decide whether Carrier has already reimbursed Renaissance a fair and reasonable amount for the services in issue in this case. If Carrier cannot establish this by a preponderance of the evidence, then it is not entitled to relief from the MDR order and the ALJs will order reimbursement consistent with the MDR order. This is the outcome the ALJs reach in this docket after considering the evidence and arguments of the parties.

At the hearing, Carrier presented no witnesses and no evidence to show that the amount it reimbursed Renaissance for the services in issue was fair and reasonable. Rather, it attacked the methodology and evidence relied on by Renaissance at MDR and before SOAH. While Carrier's attacks may have some legitimacy in raising questions as to whether the data relied on by Renaissance for determining a fair and reasonable reimbursement rate are reliable, they do nothing to show what a proper reimbursement amount should be for the services in issue. Therefore, Carrier has not met its burden of proof.

Renaissance offered evidence in support of its methodology for determining fair and reasonable reimbursement amounts. Specifically, Renaissance offered the testimony of Paul Keipper, who reviewed 600,000 records maintained by the Division between 2005 and 2009 (the time periods applicable to the services provided in these cases) to arrive at what he described as the average reimbursement amounts for the CPT codes related to the treatments in issue. He prepared

summaries of the data showing the procedures, the high reimbursements, low reimbursements, and the average amounts paid, among other things, for all of the procedures.[12]

While Mr. Keipper's analysis relied on a large volume of data, Carrier pointed out problems with the data and his analysis that render it of questionable value in establishing a fair and reasonable reimbursement rate for the procedures in issue. Among other things, Carrier noted that the data appears to include duplicate billings, possible non-outpatient treatments (lasting multiple days), and outliers that would clearly be unreasonable payments. Further, Carrier noted that Mr. Keipper did not determine whether the procedures listed in the data might include additional items billed globally and not separately for certain procedures. These are legitimate questions raised by Carrier.

However, merely casting doubt on Renaissance's proposed methodology or data does not establish that the amounts resulting from such are inherently unfair and unreasonable. Rather, it merely indicates that they have not been *proven* to be fair and reasonable. If the analysis stopped there (as Carrier asserts it should), this would essentially result in the burden of proof being shifted to Renaissance—which the ALJs concluded is not appropriate in this proceeding. It is the Carrier's burden to show that the reimbursement it has made is fair and reasonable. It is not enough to show that Renaissance's methodology or evidence may be flawed. In this case, Carrier has done nothing more than show that Renaissance's methodology or evidence is flawed. It has not put on any evidence to sufficiently establish that the amounts it has already paid resulted in a fair and reasonable reimbursement. Therefore, Carrier failed to meet its burden of proof and the ALJs find it appropriate to maintain the amount ordered by MDR. Thus, Carrier is ordered to reimburse Renaissance the additional amount of $2,190.29 for the services in dispute in this case. In support of this determination, the ALJs make the following findings of fact and conclusions of law.

[12] Respondent's Ex. F

IV. FINDINGS OF FACT

1. On November 10, 2006, hospital outpatient procedures and services (the services) were performed at a Renaissance Hospitals (Renaissance) facility for an injured worker (claimant).

2. Old Republic Insurance Company (Carrier) was the responsible workers' compensation insurer for the claimant.

3. Renaissance billed Carrier the sum of $8,544.50 for the services it provided to the claimant.

4. Carrier reimbursed Renaissance $1,118.00 for the services.

5. Renaissance requested additional reimbursement, and Carrier denied it.

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

7. On February 29, 2012, the Division issued its Medical Fee Dispute Resolution Findings and Decision (MDR Decision), ordering Carrier to pay an additional $2,190.29, plus applicable accrued interest.

8. Carrier timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the MDR 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. On September 10, 2012, a hearing convened before Administrative Law Judges Craig Bennett, Wendy Harvel, and Hunter Burkhalter at SOAH's facilities in Austin, Texas. Renaissance was represented by attorney Patrick Hyde. Carrier was represented by attorney Steven M. Tipton. The record closed on September 28, 2012, following the filing of post-hearing briefs.

11. At the time Renaissance provided the services in issue, there was no fee guideline for the services.

12. Carrier failed to present testimony or evidence to prove that the amount it had previously reimbursed Renaissance for the services in issue was fair and reasonable.

V. CONCLUSIONS OF LAW

1. SOAH 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. Carrier had the burden of proving by a preponderance of the evidence that it had already provided a fair and reasonable reimbursement to Renaissance and, thus, no additional reimbursement was due.

5. Carrier failed to prove that it has already reimbursed Renaissance a fair and reasonable amount for the services.

6. Because Carrier failed to carry its burden of proof, the ALJs find that Carrier has not shown itself entitled to relief from the MDR Decision; therefore, it is required to reimburse the additional amount of $2,190.29.

ORDER

IT IS ORDERED that Carrier pay Renaissance the additional sum of $2,190.29, plus accrued interest, in addition to the reimbursement already paid for the services in issue.

SIGNED October 31, 2012.

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

WENDY K. L. HARVEL
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

HUNTER BURKHALTER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS