MEDICAL CONTESTED CASE HEARING NO. 12124
M4-04-4963-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on June 26, 2012, with the record closing effective July 3, 2012,[1] to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the Medical Fee Dispute Resolution Findings and Decision that (Healthcare Provider) Surgical Center West is not entitled to $1630.21 in additional reimbursement for services rendered to Claimant on January 21, 2003 for the compensable injury of (Date of Injury)?

The following issue was added because it was actually litigated in the hearing:

2. Is (Healthcare Provider) Surgical Center West entitled to $1074.51 in additional reimbursement for services rendered to Claimant on January 21, 2003 for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Claimant did not appear for the hearing and his attendance was excused. Petitioner/Provider appeared and was represented by CH, attorney. Respondent/Carrier appeared and was represented by JL, attorney.

BACKGROUND INFORMATION

On January 21, 2003, Claimant underwent an outpatient contracture release of his right thumb at (Healthcare Provider) Surgical Center West ((Healthcare Provider)) as treatment for his compensable injury of (Date of Injury). (Healthcare Provider) is an ambulatory surgical center

[1] The parties (Petitioner/Provider and Respondent/Carrier) requested that the record remain open following the June 26, 2012 hearing so that they could both file written arguments. The record was initially held open until the close of business (5:00 p.m.) on June 29, 2012 for this purpose, but the deadline was extended at the request of the parties to the close of business (5:00 p.m.) on July 2, 2012. The parties both filed their written arguments by e-mail to the hearing officer on July 2, 2012, but the hearing officer did not receive them until the morning of July 3, 2012 due to her travel schedule. The record closed effective July 3, 2012.

(ASC). At the time of the date of service (DOS) in this case, there was no ASC fee guideline in place.[2] Division Rule 134.1(c), in effect from May 16, 2002 through May 1, 2006, provided that –

> "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, §413.011 until such period that specific fee guidelines are established by the commission" (emphasis added).

Division Rule 133.1(a)(8), in effect from July 15, 2000 through May 1, 2006, 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." Pursuant to the language of Texas Labor Code §413.011(d), in effect at the time of the DOS at issue, guidelines for medical services fees were required to be "fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control."

(Healthcare Provider) has the burden of proof in this case to establish its entitlement to the additional reimbursement at issue. It is undisputed that the fees for which additional reimbursement was sought in this case stemmed from a procedure performed at (Healthcare Provider)'s ASC facility and that this procedure was health care reasonably required for Claimant's compensable injury. Following this procedure, (Healthcare Provider) billed Carrier a total of $5494.96 for use of (Healthcare Provider)'s ASC facility. Carrier paid (Healthcare Provider) a total of $2236.00 based on its determination of a fair and reasonable reimbursement amount. The Medical Fee Dispute Resolution Findings and Decision (MFDRFD) issued by a Division Medical Fee Dispute Resolution (MFDR) Officer determined that (Healthcare Provider) was not entitled to $1630.21 in additional reimbursement for services rendered to Claimant on January 21, 2003. The amount in dispute in the MFDRFD appears to reflect (Healthcare Provider)'s argument at that time that it was entitled to fair and reasonable reimbursement at a minimum of 70% of its billed charges in accordance with a managed care contract. The MFDRFD indicated that no documentation was provided to support that the referenced managed care contract was in effect at the time of the DOS at issue. Additionally, the MFDR Officer's explanation, including reference to the preamble of the former *Acute Care Inpatient Hospital Fee Guideline*, was found to be highly persuasive in illustrating why payment of a percentage of a hospital's billed charges was not an acceptable method of achieving fair and reasonable reimbursement. The MFDR Officer also wrote that (Healthcare Provider) did not demonstrate how

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[2] The ASC fee guideline (Division Rule 134.402) that went into effect May 9, 2004 applied to facility services provided by an ASC on or after September 1, 2004.

it determined its usual and customary charges for the disputed services. A careful review of the probative evidence does not support (Healthcare Provider)'s entitlement to additional reimbursement in the amount of $1630.21. A preponderance of the evidence is thus found not to be contrary to the MFDRFD in this case.

At the time of the June 26, 2012 contested case hearing, however, (Healthcare Provider) was actually seeking another amount of reimbursement – $1074.51 – for the services at issue, in light of a different methodology for fair and reasonable reimbursement used by the Division in MFDRFDs in evidence dealing with Provider Renaissance Hospital (Renaissance). In support of its position on reimbursement in the amount of $1074.51, (Healthcare Provider) put forth a history of billings and reimbursements involving Carrier (and the DOS in the instant case) and three other workers' compensation insurance carriers for contracture release procedures (CPT code 26525) performed at (Healthcare Provider) in 2003. The following table by and large reflects this evidence –

Workers' Compensation Insurance Carrier	**Amount (Healthcare Provider) Billed Insurance Carrier for Contracture Release Procedure**	**Amount of Reimbursement Paid by Insurance Carrier to (Healthcare Provider) for Contracture Release Procedure**
Carrier-Legion Ins. Co.	$5494.96	$2236.00
Insurance Carrier 1	$5712.95	$5712.95
Insurance Carrier 2	$5485.96	$4663.07
Insurance Carrier 3	$6106.51	$630.00

(Healthcare Provider) took the sum total of all of the reimbursement it received from Carrier and the other three workers' compensation insurance carriers – $13242.02 – and divided this sum by four. The $1074.51 reimbursement amount sought by (Healthcare Provider) is derived by subtracting $2236.00 (the amount Carrier paid (Healthcare Provider)) from the $3310.51 average reimbursement ($13242.02 divided by four). (Healthcare Provider) contends that this methodology produces a fair and reasonable rate of reimbursement in this case.

In the Renaissance cases in evidence, MFDR Officers found in favor of Renaissance's request for additional reimbursement based on "the average amount paid by all insurance carriers in the same year for admissions involving the same principal diagnosis code and principal procedure code as the services in dispute." This methodology was found to be "the best evidence . . . of an amount that will achieve a fair and reasonable reimbursement for the services . . ." A key point in comparing the evidence relating to fair and reasonable reimbursement in the Renaissance cases

and the evidence put forth by (Healthcare Provider) in this hearing is that the methodology employed in the Renaissance cases was based on a system-wide database of charges and payments (public use data files) compiled by the Division in accordance with the directive in Texas Labor Code §413.007(a). (Healthcare Provider)'s methodology, in contrast, only took into account four admissions, one of which was for the DOS at issue in this case. The testimony of JP, business financial services director for (Healthcare Provider)'s billing and collections company, indicated that the system-wide database uses ICD-9 coding, while (Healthcare Provider) used CPT coding in its data because CPT codes are more specific.

(Healthcare Provider)'s evidence in support of its methodology for fair and reasonable reimbursement in this case, including the testimony of Ms. P, was carefully considered. Its position, however, was ultimately found not to be persuasive under the facts of this case. In particular, the widely varying nature of the reimbursement amounts in the data provided by (Healthcare Provider) – ranging from $630.00 (or approximately 10% of the billed charges) from one insurance carrier to $5712.95 (100% of the billed charges) from another – undermined the probative value of this data. Carrier's position was found to be more persuasive on the issue presented. Its contention that its $2236.00 reimbursement was fair and reasonable was found to be supported by the evidence, particularly in light of the fact that its reimbursement to (Healthcare Provider) was actually double the $1118.00 per diem in effect at the time of the DOS in this case under the Division's *Acute Care Inpatient Hospital Fee Guideline*. The evidence presented was not sufficient for (Healthcare Provider) to meet its burden of proof to establish that the $3310.51 average calculated by (Healthcare Provider) in support of the additional reimbursement at issue was a fair and reasonable rate of reimbursement in accordance with the Act and Rules. Consequently, (Healthcare Provider) is not entitled to $1074.51 in additional reimbursement in this case.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City)Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On (Date of Injury), Claimant was the employee of (Employer), Employer, and sustained a compensable injury.

   C. On (Date of Injury), Employer provided workers' compensation insurance coverage to Claimant through Legion Insurance Company, which has since been designated an impaired carrier.

D. The fees for which additional reimbursement was sought in this case stemmed from a procedure to treat Claimant's compensable injury of (Date of Injury).[3]

2. Respondent/Carrier delivered to Petitioner/Provider a single document stating the true corporate name of Respondent/Carrier, and the name and street address of Respondent/Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

1. On January 21, 2003, Claimant underwent an outpatient contracture release of his right thumb at (Healthcare Provider) Surgical Center West ((Healthcare Provider)), an ambulatory surgical center (ASC) facility, as treatment for his compensable injury of (Date of Injury).

2. At the time of the January 21, 2003 date of service (DOS) in this case, there was no ASC fee guideline in place.

3. Following the January 21, 2003 DOS, (Healthcare Provider) billed Carrier a total of $5494.96 for use of (Healthcare Provider)'s ASC facility.

4. In response to (Healthcare Provider)'s billing referenced in Finding of Fact No. 5, above, Carrier paid (Healthcare Provider) a total of $2236.00.

5. (Healthcare Provider) failed to establish that a fair and reasonable reimbursement for the services provided on January 21, 2003, is greater than the $2236.00 already paid by Carrier for the January 21, 2003 DOS.

6. The amount of reimbursement paid by Carrier to (Healthcare Provider) for the January 21, 2003 DOS is fair and reasonable.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City)Field Office.

3. A preponderance of the evidence is not contrary to the Medical Fee Dispute Resolution Findings and Decision that (Healthcare Provider) Surgical Center West is not entitled to $1630.21 in additional reimbursement for services rendered to Claimant on January 21, 2003 for the compensable injury of (Date of Injury).

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[3] This stipulation was amended from its original phrasing – "The health care for which additional reimbursement was sought in this case was provided to treat the compensable injury of (Date of Injury)" – on motion of the hearing officer and upon agreement of the parties.

4. (Healthcare Provider) is not entitled to $1074.51 in additional reimbursement for services rendered to Claimant on January 21, 2003 for the compensable injury of (Date of Injury).

DECISION

(Healthcare Provider) is not entitled to $1630.21 or $1074.51 in additional reimbursement for services rendered to Claimant on January 21, 2003 for the compensable injury of (Date of Injury).

ORDER

Carrier is not liable for the additional reimbursement at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **TEXAS PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION FOR LEGION INSURANCE COMPANY, AN IMPAIRED INSURER** and the name and address of its registered agent for service of process is

MARVIN KELLY
TEXAS PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION
9120 BURNET ROAD
AUSTIN, TEXAS 78758

Signed this 11th day of July, 2012.

Jennifer Hopens
Hearing Officer