SOAH DOCKET NO. 453-05-1481.M4
TWCC MRD NO. M4-03-0835-01

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	
	§	**OF**
TEXAS MUTUAL INSURANCE	§	
COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Vista Healthcare, Inc. (Vista) contested a decision by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) denying additional payment for ambulatory surgical center (ASC) services.[1] Until November 2002, Vista operated an ASC in Houston, Texas. ASCs provide surgical support services to patients not requiring hospitalization. In this case, Vista billed Texas Mutual Insurance Company (Carrier) for services provided to S. Q. (Claimant) on November 6, 2001. Because Carrier reimbursed Vista $1,380.00, significantly less than Vista's $19,316.09 billed charges, Vista requested medical dispute resolution before the MRD. The MRD declined to order any additional payment for the services rendered. In this proceeding, Vista seeks additional reimbursement equal to 70 percent of the unpaid balance.

After considering all of the evidence and arguments, the Administrative Law Judge (ALJ) concludes that Vista has failed to meet its burden of proof to show that it is entitled to any additional reimbursement.

The hearing in this matter convened on May 29, 2007, in Austin, Texas, with ALJ Carol Wood presiding. The record closed on July 3, 2007, upon receipt of the parties' briefs. Attorney Thomas B. Hudson, Jr., represented Carrier and attorney Cristina Hernandez represented Vista.

[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. For clarity, "the Commission" shall be used throughout. The referenced agency case number is the cause number before the Commission's MRD.

I. APPLICABLE LAW

A. Statutes and Rules

This case is governed by the Texas Workers' Compensation Act (the Act).[2] The workers' compensation insurance scheme created by the Act covers all medically necessary health care, including 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.[3]

Section 413.011 of the Act directs the Commission 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. That section of the Act further provides that guidelines for medical services fees must provide for fees that are fair and reasonable and designed to ensure the quality

[2] TEX. LAB. CODE § 401.001, *et seq.*

[3] TEX. LAB. CODE § 401.011(19) and (31). Unless otherwise noted, all cites to statutes and rules are to those in effect in 2001.

of medical care and to 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. In setting such guidelines, the increased security of payment afforded by the Act also must be considered.

In 2001, the Commission had not yet adopted payment guidelines for ASC services. Pursuant to Commission rule, an insurance carrier, in reimbursing providers for services without a fee guideline in place, was required to reimburse for those services at a fair and reasonable rate, as described in Section 413.011(b) of the Act.[5] Section 133.1(a)(8) of Commission rules defines "fair and reasonable reimbursement" 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.

Therefore, when the Commission 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 Commission in setting fee guidelines. The appropriate "fair and reasonable" reimbursement is the lowest that ensures the quality of medical care and takes into account all factors the Commission must use in setting fee guidelines.

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[4] TEX. LAB. CODE § 413.011(b).

[5] 28 TEX. ADMIN. CODE § 134.1(f).

Under the Commission's rules, carriers were required to develop and consistently apply a methodology to determine fair and reasonable reimbursement for services for which the Commission had not issued a guideline.[6]

B. Burden of Proof

As the party requesting a hearing before the State Office of Administrative Hearings (SOAH), Vista has the burden of proof.[7] That burden of proof is by preponderance of the evidence. However, due to provisions of then-applicable rule 28 TEX. ADMIN. CODE § 133.304(i)(1) that required a carrier to develop an appropriate methodology, the ALJ also required Carrier to make a showing that its payment met the statutory criteria.

II. DISCUSSION

A. Summary of Claim

On November 6, 2001, a surgeon partially removed Claimant's clavicle bone (CPT 23120; Medicare ASC Group 5) and performed arthroscopic decompression of Claimant's shoulder (CPT 29826; Medicare ASC Group 3). No complications arose in the treatment of Claimant, who was in Vista's facility for 7 1/2 hours, including approximately 2 hours in surgery and about 1 ½ hours in the recovery room.[8] The ASC provided the surgical facility, supplies, medications, and other support functions for the physician performing the procedures.

On May 15, 2003, the MRD issued an order denying additional reimbursement to Vista on the basis that Vista had failed to demonstrate that its billed charges constituted fair and reasonable reimbursement under the Commission's statutes and rules.

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[6] 28 TEX. ADMIN. CODE § 133.304(i)(1) (eff. July 15, 2000).

[7] 28 TEX. ADMIN. CODE § 148.14(a) (eff. June 9, 2005). The prior rules regarding burden of proof, located at 28 TEX. ADMIN. CODE § 148.21(h) and (i), also assigned the burden of proof to the appealing party.

[8] Ex. R-2.

B. Basis for Billed and Reimbursed Amounts

Vista asserts it is entitled to reimbursement from Carrier of 70 percent of its billed charges that is $13,521.26. Vista argues that, because it historically had received 70 percent of its billed charges from many payors, that amount represents fair and reasonable compensation. As a secondary argument, Vista asserts that, in 2001, Carrier substantially dropped its reimbursement levels without explanation. Vista contends such a change amounted to hardship for Vista and that Carrier failed to give Vista adequate notice of the change.

In establishing its payment history, Vista relied on the testimony of Jean Wincher, Vista's administrator in 2001, who oversaw admissions, billing, and collections. Ms. Wincher testified she did not participate in setting Vista's policies or practices on billing. She explained that, for the most part, Vista compared payments received from a variety of its payors, including payors reimbursing under negotiated contracts, and billed Carrier amounts similar to those payments.

Vista received payments of its billed charges at varying levels. A table of payments presented by Vista showed that in 1999 and 2000, Vista received payments from a variety of payors and those payments varied from 2.79 percent to 100 percent of its billed charges. In other words, payment of 70 percent of billed charges was not a universal practice in the industry. Vista cited an agreement it had with FOCUS Healthcare Management for the FOCUS PPO network that paid 70 percent of billed charges. Vista also provided an explanation of benefits (EOB) from Carrier dated July 27, 2001, in which Carrier had paid Vista 87 percent of billed charges.

However, Vista presented no evidence demonstrating that its determination to rely on the reimbursement amounts paid by other payors as a basis for setting billing charges for workers' compensation claims in Texas was based on an analysis of any of the factors set forth in the Act. Nor did Vista provide evidence that, when developing its billing charges, it consulted any national guidelines or norms for either ASCs or workers' compensation claims.

With regard to changes in Carrier's reimbursement levels, Ms. Wincher testified that, prior to mid-2001, Carrier had reimbursed Vista substantially more for Vista's services than

Carrier did in this case and that Carrier had reimbursed on a percentage of billed charges. She stated that Carrier did not advise Vista of the changes in Carrier's reimbursement levels and that the reasons set forth in Carrier's EOBs did not specify the changes. Ms. Wincher also testified she had attempted informally, but without success, to get clarification from Commission staff regarding appropriate methods to derive a fair and reasonable rate.

Beginning in July 1999, Carrier paid ASC billing charges based on Medicare rates.[9] Richard Ball, Carrier's senior dispute analyst, testified that Carrier's development of a reimbursement method based on Medicare rates was based largely on the Commission's 1997 determination that the Medicare population had a standard of living equivalent to workers' compensation claimants.[10] Mr. Ball noted that Carrier changed to this method for reimbursement to both hospitals and ASCs after the Commission in 1997 rejected reimbursement methods for hospitals based on a percentage of billed charges. He stated Carrier also determined that reimbursement rates based on Medicare rates would be sufficiently high to provide access to health care at ASCs for claimants covered by Carrier.

Mr. Ball, who is a registered nurse, stated that the types of procedures performed in ASCs can be performed in a hospital. He testified that Medicare currently pays $931.51 for the same procedures performed in this case. In Mr. Ball's opinion, Vista's claim for 70 percent of $19,316.09 is unreasonable.

Mr. Ball acknowledged that, in the early months of the implementation of Carrier's new reimbursement method, some errors occurred, that is, some claims were paid under Carrier's prior reimbursement method. However, based on his review of Carrier's payment records, Mr. Ball said that most claims were properly paid in accordance with Carrier's new reimbursement method. He also testified that the 2001 EOB cited by Vista, in which Carrier paid 87 percent of billed charges, concerned a case involving the federal Longshoreman and Harbor Workers Act and

[9] Carrier paid service providers approximately 120 percent of the base payment set for Medicare patients for the same or similar procedure, per the Medicare ASC Groups.

[10] The Commission determination regarding the equivalency was made in connection with the implementation of a hospital fee guideline.

was not a Texas workers' compensation case.

The EOB that Carrier issued to Vista regarding reimbursement in this case stated that the reimbursement amount of $1,380.00 had been determined by Carrier to be fair and reasonable in accordance with the criteria set forth in Section 413.011(b) of the Act.

C. Analysis

Vista's theory of reimbursement based on rates derived from a general comparison with other payors assumes that the reimbursement rates of Vista's other payors were themselves consistent with the criteria in the Act and the rules. However, Vista's reliance on data from other payors is misplaced because the record is silent as to why the other payors agreed to pay Vista the amounts they did. There is no evidence that Vista inquired into the reasons for the reimbursement amounts paid by other payors or that it conducted any analysis of how its rates – regardless of their derivation – complied with the state's statutory scheme.

Further, the large variance in payment levels received by Vista from other payors, ranging from 2.79 percent to 100 percent of billed charges, undermines Vista's assertion that reimbursement payments of 70 percent of billed charges was a standard industry practice in 2001. Vista's comparison data show only that it billed Carrier what can be characterized as its usual and customary rate. However, a provider merely billing a workers' compensation carrier its usual and customary rate does not meet the requirements for appropriate billing set forth in Section 413.011(b) of the Act. Because Vista failed to demonstrate that its billing structure took into account the statutory requirements for appropriate billing for workers' compensation claimants, Vista failed to provide any credible evidence to show that the rates it billed Carrier met the statutory criteria. Vista, therefore, failed to meet its burden of proof.

Vista's argument that Carrier's reduction in its levels of reimbursement payments constituted a hardship for Vista is irrelevant to resolving the issues in this case. Vista did not cite any authority for its position that Carrier was constrained from evaluating and changing its reimbursement practices. The EOBs and documents filed as part of the dispute resolution before the

Commission identified the grounds for Carrier's reduced payment. Furthermore, if, indeed, a duty to notify Vista existed, Vista waived any argument concerning Carrier's failure to notify it of the change because Vista failed to raise this issue before the MRD.

D. Summary

As Vista failed meet its burden of proof to show that 70 percent of its billed charges met the criteria for fair and reasonable reimbursement set forth in § 413.011 of the Act, the ALJ concludes that no additional reimbursement from Carrier is warranted. The ALJ also concludes that Carrier's reimbursement methodology considered the factors required in then-applicable 28 TEX. ADMIN. CODE § 133.304(i)(1).

III. FINDINGS OF FACT

1. ASCs provide the surgical facility, supplies, medications, and other support functions for physicians performing surgical procedures. All ASC procedures are administered on an outpatient basis.

2. On November 6, 2001,Vista provided ASC services for the partial removal of Claimant's clavicle bone (CPT 23120; Medicare ASC Group 5) and arthroscopic decompression of Claimant's shoulder (CPT 29826; Medicare ASC Group 3).

3. The services in this case were free of medical complications and involved a stay of approximately 7 1/2 hours at Vista's ASC.

4, Carrier was the responsible insurer for Claimant in 2001.

5. Vista submitted bills to Carrier in the amount of $19,316.09 for services that Vista had provided Claimant.

6. Carrier reimbursed Vista $1,380.00.

7. Carrier determined that, under the reimbursement method it employed in 2001, $ 1,380.00 constituted fair and reasonable reimbursement for the services Vista rendered.

8. Vista developed its billing charges to Carrier based on billing charges made to and paid by other payors to Vista under managed care contracts and other fee arrangements.

9. Vista did not evaluate its billing charges to determine whether those charges insured the quality of medical care for workers' compensation claimants, achieved effective medical cost control, or were comparable to fees charged for similar treatment of an injured individual of an equivalent standard of living.

10. Vista did not evaluate its billing charges in light of any national guidelines or norms for either ASCs or workers' compensation claims.

11. Vista received payment for its billed charges from other payors at varying rates and did not consistently receive payment of 70 percent of its billed charges from other payors.

12. In 2001, there was no medical fee guideline in place for ASC services.

13. Before July 1999, Carrier reimbursed claims for both ASC and other services at a percentage of billed charges.

14. In July 1999, Carrier implemented a new reimbursement method that was based on Medicare rates and did not involve payment of a percentage of billed charges.

15. In 2001, Carrier paid ASCs 100 percent of the base payment set by Medicare for the same or equivalent procedure, plus 20 percent of the median charge, weighted by total volume, per the *Ambulatory Surgical Centers 1994 Medicare Payment Rate Survey*, issued by the Health Care Financing Administration.

16. Carrier reimbursed Vista for the services listed in Finding of Fact No. 2 under the Medicare-based reimbursement formula that Carrier initiated in 1999.

17. Vista protested the reimbursement paid by Carrier and timely sought a hearing before the Commission's MRD to consider whether Vista should receive reimbursement of 70 percent of its billed charges.

18. In a decision issued on May 15, 2003, the MRD determined that Vista had failed to demonstrate that the rates it charged were fair and reasonable and so concluded that Vista was due no additional reimbursement from Carrier.

19. Vista timely requested a contested case hearing on the MRD decision.

20. The Commission issued a notice of hearing that included the date, time, and location of the hearing; the applicable statutes under which the hearing would be conducted; and a short, plain statement of matters asserted.

21. ALJ Carol Wood conducted a hearing on the merits on May 29, 2007, and the record closed July 3, 2007, when the parties filed their post-hearing briefs.

IV. CONCLUSIONS OF LAW

1. The Commission, now Texas Department of Insurance, Workers' Compensation Division, has jurisdiction over this matter pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE § 413.031.
2. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE § 401.031(d) and TEX. GOV'T CODE ch. 2003.

3. Vista's request for hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

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

5. Vista has the burden of proof by a preponderance of the evidence in this proceeding, pursuant to 28 TEX. ADMIN CODE § 148.14.

6. The services Vista provided to Claimant in this case comprised health care reasonably required and medically necessary to treat Claimant's compensable injury, within the meaning of TEX. LAB. CODE § 408.021(a)(1).

7. The services Vista provided to Claimant were not covered by a fee guideline issued by the Commission, and so were required to be billed and reimbursed at a fair and reasonable rate within the meaning of TEX. LAB. CODE § 413.011.

8. Vista failed to prove that 70 percent of its usual and customary charges that it billed for the procedure at issue constituted fair and reasonable reimbursement within the meaning of TEX. LAB. CODE § 413.011.

9. Vista failed to show by a preponderance of the evidence that it is entitled to additional reimbursement for the services at issue in this proceeding.

ORDER

IT IS THEREFORE, ORDERED that Texas Mutual Insurance Company is not required to pay any additional reimbursement to Vista Healthcare, Inc., for the ASC services Vista provided to workers' compensation claimant, S.Q., in this proceeding.

SIGNED September 4, 2007.

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CAROL WOOD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS