SOAH DOCKET NO. 453-05-8834.M4
DWC NO. M4-04-B549-01

VIRGINIA SURETY COMPANY,	**§**	**BEFORE THE STATE OFFICE**
Petitioner	**§**	
	§	
v.	**§**	**OF**
	§	
SAN ANTONIO ORTHOPAEDIC	**§**	
SURGICAL CENTER,	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Virginia Surety Company (Carrier) requested a hearing to contest the decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD)[1] ordering $3,182 in additional reimbursement for ambulatory surgical center (ASC) facility services that San Antonio Orthopaedic Surgical Center (Provider) provided to Claimant___. on February 19, 2004. The Administrative Law Judge (ALJ) finds (1) that neither party proved that it used reimbursement methodology whose application to the disputed charges produced a lower but fair and reasonable reimbursement for the charges in dispute and (2) that additional reimbursement of $3,118 is fair and reasonable, and orders that Carrier pay Provider that amount plus interest accrued.

I. JURISDICTION AND NOTICE

There were no contested issues of jurisdiction or notice. Those matters are addressed in the findings of fact and conclusions of law without further discussion here.

[1] As of September 1, 2005, the functions of the Commission were assumed by the Texas Department of Insurance, Division of Workers' Compensation.

II. PROCEDURAL HISTORY

The physicians who performed the treatments billed Carrier, and the physicians' charges are not in dispute in this proceeding, nor is there a dispute about the treatments given. Rather, what is in dispute is the amount billed separately by Provider for its ASC facility charges associated with the procedures performed by the treating physicians.

The MRD issued its decision on June 28, 2005. Carrier filed a timely request for hearing on July 13, 2005. The case was initially set for hearing at the State Office of Administrative Hearings (SOAH) on December 30, 2005, but that hearing was not held due to pending litigation concerning the Commission's rules regarding ASC reimbursement, *Texas Workers' Comp. Comm'n v. East Side Surgery Center*, 142 S.W.3d 541, 549 (Tex. App.--Austin 2004, no pet.). After that litigation concluded, this case was again set for hearing on May 29, 2007.

On May 29, 2007, SOAH Administrative Law Judge Charles Homer III held a contested case hearing at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Carrier appeared at the hearing through its attorney, William E. Weldon. Provider appeared through its attorney, Daniel R. Smith. The record closed on the same day.

III. DISCUSSION

On____, Claimant____, a 63-year-old man, was injured on the job and required arthroscopic surgery on his right shoulder for diagnoses of sprained rotator cuff and acromioclavicular sprain. He underwent surgery for these conditions on February 19, 2004, which consisted of four procedures, arthroscopy, acromiopasty, subacromial decompression, and large, complex rotator cuff repair. Provider billed Carrier $31,996.00 for these services. Carrier paid $1,118 for services under CPT codes 29826, 29824, 29821, and 29827, $1,055.70 for implantables, and denied payment of Provider's additional charges for services.

At an MRD review that Provider requested, the MRD determined that neither party had presented sufficient evidence of a methodology that resulted in a "fair and reasonable" charge as required. The MRD performed its own analysis based upon both an Ingenix survey of ASC charges and the Medicare fee guidelines (MFG) then in effect (June 19, 2005), and found that Provider should be reimbursed a total of $4,300 in addition to the implantables. This amounted to an award of additional reimbursement totaling $4,300 minus $1,118 already paid, or $3,182.

Carrier requested a hearing, and asserts at SOAH that such reimbursement exceeds a fair and reasonable amount. Provider responds that the MRD award is fair and reasonable, and that because the ambulatory surgical center fee guideline (ASCFG) was not in effect at the time of the procedure, it cannot serve as a cap on an award that is fair and reasonable. (As shown in the table at Finding of Fact No. 15, applying the current 213.3% ASCFG protocol results in a charge of $3313.76, exclusive of implantables.)

The parties also dispute whether the amount Carrier paid Provider for the implantables should be considered in this proceeding as a credit to Carrier. Provider urges that it did not appeal the award and that Carrier, who did not cross-appeal to the MRD, is raising the payment at SOAH for the first time.[2] Carrier responds that if an award of additional reimbursement is made, it should have a credit for its implantables payment because under the May 2004 version of the ASCFG,[3] implantables were included in the charges for the service and not "carved out" for separate reimbursement as they are now under a 2005 change in the rule. (Although it did not specifically provide additional reimbursement for implantables when first adopted, 28 TAC § 134.402 was amended in 2005 to allow a "carve-out" for implantables, which is cost plus 10%.)[4]

At the hearing, the ALJ assigned Carrier the initial burden of showing that its payment

[2] The MRD decision noted that "An orthopedic implant was used that is not in dispute." Its decision did not further address Carrier's previous payment for implantables. Carrier Ex. 6.

[3] 29 Tex. Reg. 4191 (April 30, 2004.)

[4] 28 Tex. Admin. Code (TAC) § 134.402(e)(4), added by amendment March 4, 2005. 30 Tex. Reg. 1290.

methodology resulted in a fair and reasonable payment, with the burden of proving that the MDR decision produced a fair and reasonable result to fall on Provider if Carrier failed to make its case. Carrier presented only documentary evidence, including a spreadsheet of Provider's services billed, amounts actually paid, and amounts that would be paid under the MDR decision and under the ASCFG adopted May 2, 2004.

Provider relied in part on Carrier's exhibits and offered two additional documents, the "case costing report" for the disputed services and a history of the claim called a "comment listing." All exhibits were admitted into evidence.

Provider also called Ms. Susan Nix, Director of Reimbursement for an administrative company that handles billing and insurance matters for Provider and its associated group of physicians. Ms. Nix has held her position for nearly six years, and in that capacity she is responsible for all managed care reimbursement, contracts and contract enforcement as to deductibles, and for administrative and front office staff. She also reports monthly to the physicians in the related medical practice group on the cost effects of contracts and procedures performed.

Reviewing Provider's expenses related to the disputed services, Ms. Nix stated that, including the implantables (surgical screws) and operating room, Provider's expenses for Claimant's treatment amounted to $2,898.08 exclusive of administrative time and infrastructure charges. Ms. Nix stated that after deducting Carrier's payment of $1,118 for services and removing Provider's $1,248 charge for the implantables,[5] Provider would lose $532.08 for treating Claimant if it were not additionally reimbursed. She stated that Carrier stopped taking workers' compensation cases in October 2004, when it became clear that the ASCFG would be applied to ASC services and implantables.

Ms. Nix also testified that at present Provider has contracts with three of the 14 private

[5] Ms. Nix actually removed the billed amount, $1,248, from her calculation, and thus credited Carrier for full payment of it even though Carrier actually paid only $1,055.70.

workers compensation insurance carriers authorized in Texas. She stated that these contracts provide for payment at 250% of MFG plus reimbursement for implantables at cost plus 10%, and that Provider is presently providing services under those contracts. The contracts carve out shoulder, knee, and ankle arthroscopies for reimbursement at $3,900 - $4,000.

IV. ANALYSIS AND CONCLUSION

Carrier argues that by paying $1,055.70 for implantables and $1,118 for Provider's services it has made a fair and reasonable payment. The ASCFG rule provides that payment will be at 213.3% of the MFG for the primary service and all secondary services at 213.3% times 50% of MFG, or a total of $3,313.76 in this case.[6] Carrier's assertion that its payment of $1,118 for medical services is fair and reasonable rests solely upon the 2004 ASCFG, without consideration of the 2005 amendment of the ASCFG to allow reimbursement for implantables at cost + 10% in addition to the reimbursement for services.[7]

Carrier did not tie the $1,118 it paid for Provider's services to any objective legal or quantitative methodology or standard to show that it is a fair and reasonable amount for services billed. Its total payment of $2,173.70 did not match the $3,313.76 ASCFG adopted by the Commission soon after the disputed services were rendered.

[6] 28 TAC 134.402(c) - (e) (eff. March 4, 2005.)

[7] 30 Tex. Reg. 1290 (2005). (Among other changes, subpart (e)(4), addressing surgical implantables, was added to the Commission rule at 28 TAC § 134.402.)

On the other hand, Provider, through Ms. Nix's testimony, demonstrated that Texas workers compensation carriers will contract today to pay $3,900 for shoulder procedures such as this one and pay an additional cost-plus-10% charge for implantables. While this amount is doubtless somewhat higher than would have been charged in 2004 because of the steady increase in the cost of medical services in general, the amount is some evidence of a methodology that produces a fair and reasonable rate.[8] It is unlikely that workers compensation carriers would presently be contracting and doing business with Provider for the same services as rendered to Claimant for a cost that significantly exceeds the ASCFG.

Although $4,300 is far less than Provider billed Carrier for its services, Provider did not appeal and thereby assume the burden of proving that its usual and customary charges at the time of surgery were fair and reasonable. Rather, as the prevailing party at the MRD who did not appeal the MRD decision, Provider's burden is to show that $4,300 is a fair and reasonable result. In ordering total payment of $4,300, the MRD compared results from Medicare and Ingenix and selected one that was in the "medium to high" of the Ingenix range, which ran from 213.3% to 290% of Medicare. The $4,300 award is very close to the current ASCFG in that it nearly equals $4,369.46, which is the sum of the $3,313.76 ASCFG for services plus Carrier's payment for implantables of

[8] Tex. Labor Code Ann. § 413.011(d) provides that:

> Notwithstanding Section 413.016 or any other provision of this title, an insurance carrier may pay fees to a health care provider that are inconsistent with the fee guidelines adopted by the division if the insurance carrier or a network under Chapter 1305, Insurance Code, has a contract with the health care provider and that contract includes a specific fee schedule.

In this particular case, Provider's current contract amount is very close to the fee guideline.

$1,055.70 as a substitute for the currently allowed cost plus 10% for implantables.

Under the circumstances of this case, the ALJ finds that Provider has shown that the amount awarded by the MRD is fair and reasonable that the decision should be upheld. Carrier will be ordered to pay Provider $3,382.00 plus interest accrued under applicable law.

V. FINDINGS OF FACT

1. Claimant ___suffered a compensable injury on____, while he was employed by an employer carrying workers' compensation insurance underwritten by Virginia Surety Company (Carrier).

2. As a result of his injury, Claimant underwent shoulder surgery including arthroscopy, acromioplasty, subacromial decompression, and rotator cuff repair at San Antonio Orthopaedic Surgical Center (Provider) on February 19, 2004.

3. Before adjustments, Provider charged Carrier $35,034.00 for the ambulatory surgical center (ASC) services associated with the procedure performed on the Claimant.

4. Carrier reimbursed Provider $1,118 for the ASC services provided plus $1,055.70 for implantables, for a total reimbursement of $ 2,173.70.

5. Provider submitted a request for medical dispute resolution on August 12, 2004, with the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission).

6. After adjustments agreed between the parties, the amount in dispute at MRD was $31,996.00.

7. The MRD performed its own analysis based upon both the Ingenix survey of charges and the ASCFG that by then (June 19, 2005) was in effect, and found that Provider should be reimbursed a total of $4,300 apart from the implantables.

8. Carrier filed a timely request for a hearing, and the Commission issued a timely notice of hearing and referred the cases to the State Office of Administrative Hearings for assignment of an Administrative Law Judge to hear the disputes.

9. All parties received adequate notice of not less than 10 days of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

10. A hearing was held on May 29, 2007, at which both parties appeared through counsel.

11. Under the Medicare and ASCFG, the payment amounts for facility services associated with CPT codes listed below was:

CPT Code	Provider's Charge	Medicare Fee Guideline (MFG)	current ASCFG
29827	NA	$702.54	MFG x 213.3% $1498.52
29824	NA	$702.54	50% MFG x 213.3% 749.26
29821	NA	$499.76	50% MFG x 213.3% $532.90
29826	NA	$499.76	50% MFG x 213.3% $532.90
Total Medicare Amount for Four Procedures	$31,996.00		$3313.76

12. Provider presently has contracts with three of the 14 Texas network workers' compensation insurance carriers for reimbursement at 250% of Medicare rates with carve-outs for arthroscopic shoulder procedures at $3900-$4000 in addition to cost plus 10% for implantables.

13. Medicare fees came into use as a benchmark in the Texas workers' compensation system by rule adopted May 2, 2004, to become effective September 1, 2004.

14. Carrier reimbursed Provider $1,118 for services, which is $2,195.76 less than the Medicare rate for the rotator cuff repair and related services provided by Provider, excluding implantables.

15. The current workers' compensation ambulatory surgical center fee guideline (ASCFG) for facility services provided by an ASC indicates that payment at or near that amount is fair and reasonable for services rendered approximately three months before the adoption of the original (ASCFG) and approximately 13 months before the ASCFG was amended to include

cost plus 10% reimbursement for surgical implantables.

16. Provider presently has contracts with three of the 14 Texas network corkers' compensation insurance carriers for reimbursement at 250% of Medicare rates with carve-outs for arthroscopic shoulder, ankle, and knee procedures at $3,900 - $4,000 in addition to cost plus 10% for implantables.

17. Payment of $3,900 to $4,000 and the cost of implantables plus 10% approximates the current ASCFG for the disputed charges.

18. For the disputed services, the current ASCFG is $4,369.46, which is the sum of the $3,313.76 ASCFG for services plus Carrier's payment for implantables of $1,055.70.

VI. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. §§ 413.073(b) and 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003 and Acts 2005, 79th Leg., ch. 265, § 8.013, eff. Sept. 1, 2005.

2. A SOAH administrative law judge may issue a final order resolving a contested case withoutan evidentiary hearing if the pleadings show that there is no genuine issue as to any materialfact and that a party is entitled to a decision in its favor as a matter of law. 1 TEX. ADMIN. CODE (TAC) § 155.57(a).

3. Title 28 TAC § 134.401(a)(4) (eff. Aug. 1, 1997) provided as follows:

> Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements.

4. Title 28 TAC §134.1(f) (eff. Oct. 7, 1991) provided as follows:

> 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, § [413.001] until such period that specific fee guidelines are established by the commission.

5. Subsection (b) of TEX. LABOR CODE ANN § 413.011 (Acts 1993, 73rd Leg., ch. 269, § 1, eff. Sept.1, 1993), which was then entitled *Guidelines and Medical Policies* provided that:

> 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.

6. Carrier failed to show that its payment methodology is consistent with TEX. LABOR CODE ANN. 413.011 and 28 TAC § 133.304(i)(1) (eff. July 15, 2000), which required carriers "to develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts" for services for which the Commission had not established a maximum allowable reimbursement.

7. While contract rates by themselves provide guidance only about an upper limit of fair and reasonable charges, in connection with evidence of guidelines adopt after the disputed procedure, current contract rates that are actually being charged to and paid by currently authorized Texas workers compensation insurance carriers provide some evidence that a charged based on those rates is fair and reasonable.

8. The current workers' compensation ambulatory surgical center fee guideline (ASCFG) for facility services provided by an ASC is based upon the Medicare payment policies for those services and the Medicare ASC reimbursement amount for the primary procedure multiplied by 213.3%, plus 50% of the Medicare ASC reimbursement amount for each secondary procedure, plus reimbursement at cost plus 10% for surgical implantables. 28 TAC 134.402(c) - (e).

9. Based on Findings of Fact Nos. 11-18 and Conclusions of Law Nos. 3-8, the payment awarded by the MRD constituted a fair and reasonable reimbursement for the ASC facility services provided by Provider.

ORDER

IT IS HEREBY ORDERED that Virginia Surety Company pay $3,382.00 additional reimbursement to San Antonio Orthopaedic Surgical Center for the services provided Claimant ___in this matter, together with legally authorized interest accrued thereon.

SIGNED July 27, 2007.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS