SOAH DOCKET NOS. (SEE ATTACHMENT)

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
(SEE ATTACHMENT),	§	
Respondents	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Vista Healthcare, Inc. (Vista) requested a hearing to contest decisions by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) denying additional payment for ambulatory surgical center services.[1] Vista operated ambulatory surgical centers (ASCs) in Houston, Texas, and provided surgical services to patients not requiring in-patient hospitalization. As related to these dockets, Vista billed certain Insurance Companies (Carriers) for services provided to seventeen claimants.[2] Carriers reimbursed Vista less than the billed amount and Vista requested medical dispute resolution before MRD. MRD subsequently declined to order any additional payment for the services. In this docket, Vista has the burden of proving that it is entitled to additional payment for the services rendered. After considering all of the evidence and arguments, the Administrative Law Judge (ALJ) concludes that Vista has failed to meet that burden; therefore, it is not entitled to any additional reimbursement.

[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. This case arose before that transfer of authority, but only recently went to hearing because of related ongoing litigation that had a bearing on the handling of ambulatory surgical center cases.

[2] Because these cases were heard together, the ALJ issues this single decision in the seventeen dockets involved.

II. APPLICABLE LAW

The Texas Workers' Compensation Act (the Act) is found at TEX. LAB. CODE ANN. § 401.001, *et seq.* Under the Act, workers' compensation insurance 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 provides that the Commission, 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 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.[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 must be considered.

However, during all time periods relevant to this case, the Commission had not established any payment guidelines for ASC services. In such a situation, an insurance carrier is required to reimburse the services at fair and reasonable rates as described in Section 413.011(d) of the Act.[5] Fair and reasonable is defined 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

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[3] TEX. LAB. CODE ANN. § 401.011(19) and (31). Unless otherwise noted, all cites to statutes and rules are to those in effect in 2001—during the relevant time periods in issue in this case.

[4] § 413.011(d) of the Act.

[5] 28 TEX. ADMIN. CODE (TAC) § 134.1(f).

(C) a negotiated contract amount.[6]

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 one that ensures the quality of medical care and accounts for the factors used by the Commission in setting fee guidelines.

III. DISCUSSION AND ANALYSIS

In each of the seventeen dockets involved in this case, the claimant sustained a work-related injury. The compensability of the injuries is not in dispute. The claimants all received care at a Vista ASC facility. The physicians performing the treatments billed Carriers, 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 Vista for its facility charges associated with the procedures performed by the treating physicians.

In each of the dockets, Vista billed Carriers its usual and customary charges, depending on the surgery performed. The table attached as Appendix A sets out the amount billed by Vista and the amounts paid by Carriers. As noted on the table, Carriers reimbursed a portion of the amount billed in each instance, an amount equal to or greater than the maximum allowable reimbursement (MAR) under the hospital fee guideline for a hospital billing for similar services ($1,118.00). In this matter, Vista seeks additional reimbursement that would provide it a total reimbursement equal to 70 percent of its billed charges.

The ALJ is not persuaded, however, that Vista's customary and usual billing practices and what it typically has received in reimbursement for its services establishes a fair and reasonable reimbursement rate. Billed charges and historical reimbursement rates, by themselves, do not show compliance with the factors identified in Section 413.011 of the Act for determining a fair and reasonable reimbursement. The amounts that other carriers have paid may be some indication of

[6] 28 TAC § 133.1(a)(8).

what might be a fair and reasonable amount, but by itself that information is not dispositive under the statutory guidelines.[7] There can be many reasons why a carrier might reimburse higher than what would be reasonable under a certain circumstance, not the least of which is simply a mistake.

Although it may not be Vista's responsibility to consider the statutory factors in developing its usual and customary charges, it is Vista's burden to show that the reimbursement amounts sought satisfies these factors and, thus, are fair and reasonable under the Act. Vista's evidence has not established this. Vista offered into evidence a summary of its 2001 billings and the percentages paid by various carriers; Medicare, Medicaid, and private entities. The amounts Vista charged for the same or similar services varied significantly. Moreover, the percentages paid ranged from four percent to 170 percent, well over the amount billed. Objections were raised to the admissibility of this summary that were sustained. Vista's only witness, Jean Wincher,[8] could not identify the statutory factors to consider when determining a fair and reasonable reimbursement,[9] and did not know how Vista determined the amount it charged for the various services. Ms. Wincher agreed that the billed amounts for the same or similar services varied greatly, and that the percentages paid ranged from very low amounts to over 100 percent of that billed. Ms. Wincher could not explain why the percentages paid would be over a 100 percent. None of its documentary evidence shows how 70 percent of Vista's billed charges would comply with the statutory factors for determining a fair and reasonable reimbursement.

Further, the ALJ finds a vast discrepancy between what Vista billed for the procedures in issue and the MAR for hospitals for the same procedures for a one-day stay and treatment, including operating room, recovery room, medications, and supplies. While there may be reasons that ASCs are entitled to greater payment than hospitals, Vista has not adequately demonstrated that in this proceeding or justified such a vast discrepancy between its billings and the MAR for hospitals performing similar procedures. The ALJ is not persuaded that ASCs, for a few hours' worth of facility services, are entitled to more than three or four times the reimbursement for hospitals providing full day stays. Vista has not justified its billing rate, except to say that the market has

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[7] In fact, the Commission has previously rejected a "percentage of billed charges" methodology for determining fair and reasonable reimbursement amounts because it does not comply with the statutory directive of cost control.

[8] Ms. Wincher is the vice-president of billing services for Doctors Practice Management, and is in charge of Vista's admissions, billings, and collections.

been willing to pay these amounts in the past. This is insufficient for purposes of establishing that the amounts are fair and reasonable under the Act. Therefore, because Vista has failed to show that its charges (or even 70% of its charges) represent fair and reasonable reimbursements under the applicable legal guidelines, the ALJ concludes that Vista is not entitled to any additional reimbursement. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.[10]

IV. FINDINGS OF FACT

1. Vista HealthCare, Inc. (Vista) operated ambulatory surgical centers (ASCs) in Texas, and provided surgical services to patients not requiring in-patient hospitalization.

2. Each of the claimants involved in the seventeen dockets addressed by this order received care at a Vista ASC facility for their compensable, work-related injuries.

3. The claimants received various surgical procedures.

4. The Insurance Carriers (Carriers) are responsible for the workers' compensation insurance benefits administered to each of the claimants.

5. Vista billed Carriers its usual and customary charges for the services provided to each of the seventeen claimants, with those charges ranging from a low of $4,651.91 to a high of $22,400.95, depending on the surgery performed.

6. Carrier's reimbursed portions of the amount billed, at an amount equal to or greater than the maximum allowable reimbursement (MAR) under the hospital fee guideline for a hospital billing for similar services.

7. Vista sought additional reimbursement and submitted to the Commission a request for dispute resolution in each of the seventeen dockets.

8. MRD issued its Findings and Decision in each of the seventeen dockets, ordering no additional reimbursement by Carrier.

9. Vista requested a hearing in each docket, 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.

10. 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

[10] The findings and conclusions apply to each of the dockets involved. Because the outcome of this case does not rest on any claimant-specific circumstances, the ALJ makes no specific findings related to the individual claimants or their injuries.

particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

11. On June 25, 2007, SOAH Administrative Law Judge Catherine C. Egan held a contested case hearing concerning the seventeen referenced dockets at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Carriers appeared at the hearing through their attorney, Jack Latson. Vista appeared through its attorneys, Cristina Hernandez and Eric Carter. The record closed on July 23, 2007, following the filing of written closing arguments.

12. The reimbursements that Vista has received from different entities for the same services in issue in this proceeding varied significantly.

13. The percentages paid by different entities for the charges Vista billed for its services in 2001 ranged from very low percentages to over a 100 percent.

14. The amount Vista billed and the amount Vista now seeks in reimbursement for each of the surgical procedures exceed the amount of reimbursement a hospital would have received for the same procedures performed in the hospital, $1,118.00 a day for a patient's stay and treatment, including operating room, recovery room, medications, and supplies.

V. CONCLUSIONS OF LAW

15. The Texas Workers' Compensation Commission (Commission)(now the Division of Workers' Compensation of the Texas Department of Insurance) has jurisdiction over this matter pursuant to the Texas Workers' Compensation Act. TEX. LAB. CODE ANN. § 413.031.

16. 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 ANN. §§ 402.073 and 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

17. In each case in issue in this proceeding, the request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE (TAC) § 148.3.

18. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

19. 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 get or keep employment. TEX. LAB. CODE ANN. § 401.011(19) and (31).

20. In each of the seventeen dockets in this proceeding, Vista had the burden of proving by a preponderance of the evidence that it was entitled to additional reimbursement. 28 TAC § 148.21(h).

21. 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, Section 8.21(b), until such time that specific guidelines are established by the commission. 28 TAC § 134.1(f) (Emphasis added).

22. 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 fee guidelines. TEX. LAB. CODE ANN. § 413.011.

23. A "usual and customary" charge may be the same as a "fair and reasonable" reimbursement amount only if there is evidence that the factors set out in § 413.011 of the Act are satisfied; that is, that the amount achieves effective medical cost control, taking into account payments made to others with an equivalent standard of living, and considering the increased security of payment. 28 TAC § 133.1(a)(8).

24. Vista failed to show that its usual and customary billed charges or even 70 percent of its billed charges, the amount sought by Vista in this proceeding, are fair and reasonable.

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

ORDER

Having found that Vista HealthCare, Inc. has not shown itself entitled to relief from the orders of the Medical Review Division of the Texas Workers' Compensation Commission in the underlying cases, **IT IS, THEREFORE, ORDERED** that the Insurance Companies named in this proceeding are not required to provide any additional reimbursement for the services in issue in the seventeen dockets in this proceeding.

SIGNED September 21, 2007.

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

ATTACHMENT

DOCKET NO.	MDR NO.	STYLE
453-02-3975.M4	M4-02-2121-01	Vista HealthCare, Inc. vs. TPCIGA for Reliance National Indemnity Company
453-03-0055.M4	M4-02-2264-01	Vista HealthCare, Inc. vs. TPCIGA for Reliance National Indemnity Company
453-03-0056.M4	M4-02-3653-01	Vista HealthCare, Inc. vs. TPCIGA for Reliance National Indemnity Company
453-03-0057.M4	M4-02-3127-01	Vista HealthCare, Inc. vs. TPCIGA for Reliance National Indemnity Company
453-05-1522.M4	M4-03-0537-01	Vista HealthCare, Inc. vs. TPCIGA for Reliance National Indemnity Company
453-03-0146.M4	M4-02-2154-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-03-0556.M4	M4-02-3103-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-03-0579.M4	M4-02-2888-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-03-0630.M4	M4-02-3844-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-03-1766.M4	M4-02-2413-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-03-3012.M4	M4-02-3847-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-03-3969.M4	M4-03-0211-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-03-3970.M4	M4-03-0260-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-05-0559.M4	M4-03-4213-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-05-0561.M4	M4-03-3908-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-03-0576.M4	M4-02-2103-01	Vista HealthCare, Inc. vs. American Home Assurance Company
453-03-0578.M4	M4-02-3112-01	Vista HealthCare, Inc. vs. American Home Assurance Company

APPENDIX A

Cause No.	Surgery	Date of Service	Total Charged*	Amt. Paid*
453-02-3975.M4	**Lumbar Facet Injections**	**02-23-01**	**$5,674.85**	**$1,118.00**
453-03-0055.M4	**Lumbar Facet Injections**	**01-19-01**	**$4,651.97**	**$1,118.00**
453-03-0056.M4	**Shoulder Arthroscopy**	**05-29-01**	**$16,339.71**	**$2,236.00**
453-03-0057.M4	**Radio Frequency Neurolysis**	**04-04-01**	**$9,104.93**	**$1,118.00**
453-05-1522.M4	**Contracture Release of PIP Joint**	**10-23-01**	**$6,979.54**	**$1,118.00**
453-03-0146.M4	**Shoulder Arthroscopy**	**02-27-01**	**$22,400.95**	**$14,550.95**
453-03-0556.M4	**Cervical Discogram**	**04-30-01**	**$8,410.95**	**$6,441.00**

453–03-0579.M4	**Spinal Manipulations**	**05-02-01**	**$5,542.46**	**$3,157.47**
453-03-0630.M4	**Shoulder Arthroscopy**	**06-19-01**	**$17,120.47**	**$10,621.97**
453-03-1766.M4	**Cervical Discogram**	**03-01-01**	**$10,401.32**	**$6,622.15**
453-03-3012.M4	**Lumbar Facet Injections**	**06-11-01**	**$7, 610.45**	**$1,118.00**
453-03-3969.M4	**Decompression of Rotator Cuff**	**10-09-01**	**$15,386.64**	**$1,118.00**
453-03-3970.M4	**Excision of Loose Bodies in Ectopic Bone**	**09-25-01**	**$15,967.28**	**$9,104.52**
453-05-0559.M4	**Knee Arthroscopy**	**03-11-02**	**$13,655.51**	**$4,643.14**
453-05-0561.M4	**Knee Arthroscopy**	**03-19-02**	**$12,511.04**	**$5,427.18**
453-03-0576.M4	**Lumbar myelogram**	**02-21-01**	**$6,833.01**	**$5,808.50**
453-03-0578.M4	**Shoulder Arthroscopy**	**05-10-01**	**$21,508.76**	**$13,608.04**

*** This is the amount in the MRD decision.**