SOAH DOCKET NO. 453-02-3979.M4
SOAH DOCKET NO. 453-03-0058.M4

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
HARTFORD ACCIDENT &	§	
INDEMNITY COMPANY,	§	
Respondent	§	**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 Hartford Accident & Indemnity Company (Carrier) for services provided to the claimant.[2] Carrier reimbursed less than the billed amount and Vista requested medical dispute resolution before MRD, which 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.[3] 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.

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[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 two dockets involved.

[3] Vista, as the party seeking to overturn the MRD's decision, has the burden of proof under TEX. LAB. CODE ANN. § 413.031. See also SOAH rule 28 TEX. ADMIN. CODE § (TAC) 148.14(a) (eff. June 9, 2005). The prior rules regarding burden of proof, located at 28 TAC § 148.21(h) and (i), also assigned the burden of proof to the party seeking affirmative relief.

II. APPLICABLE LAW

This case is governed by the Texas Workers' Compensation Act (the Act).[4] 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.[5]

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 of medical care and to achieve effective medical cost control.[6] 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. In reimbursing providers for services without a fee guideline in place, an insurance carrier is required to reimburse for those services at a fair and reasonable rate, as described in Section 413.011(d) of the Act.[7] The then-applicable rule, 28 TAC § 133.1(a)(8), defined "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

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

[5] 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.

[6] TEX. LABOR CODE ANN. § 413.011(d).

[7] 28 TEX. ADMIN. CODE § 134.1(f).

> (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.[8]

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 takes into account all factors the Commission must use in setting fee guidelines.

III. DISCUSSION

A. Background Facts

The claimant sustained work-related injuries. The compensability of the injuries is not in dispute. Claimant received care at a Vista ASC facility. The physicians performing the treatments billed Carrier, and the physicians' charges are not in dispute in this proceeding; nor is there a dispute about the treatments given.[9] 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.

For the claimant in 453-02-3979.M4, Vista billed Carrier its usual and customary charge of $6,649.70 for services rendered on April 5, 2001. Carrier reimbursed Vista $1,118.00, an amount representing approximately 17% of the billed amount. For claimant in 453-03-0058.M4. Vista billed Carrier its usual and customary charge of $6,374.82 for services rendered on May 25, 2001. Carrier reimbursed $1,118.00, an amount representing approximately 17.5% of the billed amount. In this matter, Vista seeks additional reimbursement of $6,881.76, plus interest, which would equal 70% of its billed charges.

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[8] *Compare* 28 TAC § 134.1(c) - (e).

[9] Claimant underwent lumbar epidural steroid injections on both dates of service.

B. Evidence

To support its request for additional reimbursement, Vista presented evidence of its billing practices, in the form of a spreadsheet that showed the amount of reimbursement it typically received from other insurance carriers and governmental bodies for the ASC services it provided in 2001.[10] Vista argues that it is entitled to additional reimbursement essentially because it historically has received a level of reimbursement from other insurance companies and Medicare that is higher than that offered by Carrier in this case. In particular, according to the data presented by Vista, its average reimbursement rate for ASC services has been approximately 60% of billed charges. Further, its median reimbursement has been 70% of billed charges.[11] In fact, at least one of Vista's contracts with a health network (representing numerous insurance carriers) provided that Vista would be reimbursed at 70% of its billed charges.[12]

However, the evidence also indicated that Vista received payment of its billed charges at varying levels. Vista's own spreadsheet showed that in 2001, Vista received payments varying from 4% to 100% of its billed charges from a variety of payors. In other words, payment of 70% of billed charges was not a universal practice in the industry.

Vista also presented testimony from Jean Wincher, who was Vista's administrator who oversaw admissions, billing, and collections for Vista. She testified she did not participate in setting Vista's policies or practices on billing, including Vista's Chargemaster[13] system. Ms. Wincher explained that, for the most part, Vista compared payments received from a variety of its payors, including carriers reimbursing under negotiated contracts, and billed Carrier amounts similar to those amounts. She also stated that she had attempted informally, but without success, to get

[10] Vista's Exhibit No. 1, is a table delineating variables including CPT code, date of service, amount billed, amount paid, percentage of the billed amount paid, and carrier name for approximately 2000 procedures performed in 2001.

[11] In essence, half of all procedures were reimbursed at higher than 70% of billed charges, while half were reimbursed at less than 70% of billed charges. See Vista's Exhibit No. 1 at page 51.

[12] Vista cited an agreement it had with Focus Healthcare Management for the Focus PPO Network, which paid 70% of billed charges.

[13] According to Ms. Wincher, Chargemaster is a program that assigns and correlates billing amounts with various CPT codes and medical procedures.

clarification from Commission staff regarding appropriate methods to derive a fair and reasonable rate. Based on this evidence, Vista argues that it is entitled to be reimbursed at 70% of its billed charges for the services at issue in these dockets.

C. Analysis

Vista's theory of reimbursement based on charges derived from a general comparison with other payors assumes that the reimbursement rate of Vista's other payors were themselves consistent with the criteria in the Act and rules. The ALJ is not persuaded that Vista's evidence of its billing practices and what it typically has received in reimbursement for its services establishes a fair and reasonable reimbursement rate. Vista's reliance on the data from the other payors is misplaced because the record is silent as to why the other payors agreed to pay Vista the amounts they did. Additionally, there is no evidence that Vista inquired into the reasons for the reimbursement 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. 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 what *might* be a fair and reasonable amount, but by itself that information is not dispositive under the statutory guidelines.

The large variance in payment levels received by Vista undercuts Vista's assertion that 70% of billed charges was a fair and reasonable reimbursement amount. Vista's payment data provides little persuasive value when it shows wide variations in reimbursement amounts.

Vista failed to meet its burden of proof because it presented no evidence that it developed a billing structure that took account of the state's requirements for rates for reimbursing workers' compensation providers. Additionally, Vista failed to provide any credible evidence to show that the rates they billed Carrier met the statutory criteria.

D. Conclusion

Vista failed to show that the reimbursement amount sought is fair and reasonable under the Act and ALJ concludes that no additional reimbursement is warranted. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.[14]

IV. FINDINGS OF FACT

1. The same claimant involved in the two dockets addressed by this order received care at a Vista ASC facility for compensable, work-related injuries.

2. Claimant received the same medical procedure on two different dates of service; (1) lumbar epidural steroid injection and flouroscopy (CPT Code 62289) on April 5, 2001; and (2) lumbar epidural steroid injections and flouroscopy (CPT Code 62311).

3. Hartford Accident & Indemnity Company (Carrier) is the insurance carrier responsible for the workers' compensation insurance benefits administered to the claimant.

4. Vista billed Carrier its usual and customary charges for the services provided to the claimant, with those charges being $6,649.70 (CPT Code 62289) and $6,374.82 (CPT Code 62311).

5. For the charge of $6,649.70, Carrier reimbursed Vista $1,118.00, an amount representing approximately 17% of the billed amount.

6. For the charge of $6,374.82, Carrier reimbursed Vista $1,118.00, an amount representing approximately 17.5% of the billed amount.

7. Vista sought additional reimbursement and submitted to the Texas Workers' Compensation Commission (Commission) (now the Division of Workers' Compensation of the Texas Department of Insurance) a request for dispute resolution in each of the dockets.

8. The Commission's Medical Review Division issued its Findings and Decision in each of the 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 (SOAH) for assignment of an Administrative Law Judge (ALJ) 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 particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

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[14] The findings and conclusions apply to each of the dockets involved.

11. On July 2, 2007, ALJ Steven M. Rivas held a contested case hearing concerning the two referenced dockets at the SOAH, William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Vista appeared at the hearing through its attorney, Cristina Hernandez. Carrier appeared through its attorney, James Loughlin. The record closed on July 30, 2007, after the parties submitted closing written arguments.

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

V. CONCLUSIONS OF LAW

13. The State Office of Administrative Hearings (SOAH) has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

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

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

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

17. 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).

18. 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).

19. At the time Vista provided ASC services to Claimant, the Commission had not adopted an ASC Fee Guideline.

20. 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 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 Hartford Accident & Indemnity Company is not required to provide any additional reimbursement for the services in issue in the two dockets in this proceeding.

SIGNED September 6, 2007.

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS