SOAH DOCKET NO. 453-03-0540.M4
MRD No. M4-02-3525-01

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
v.	§	
MID-CENTURY INSURANCE	§	
COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

I. INTRODUCTION

Vista Healthcare, Inc. (Vista) requested a hearing to contest a decision 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. Vista billed the Respondent Insurance Carrier (Carrier) for services provided to a workers' compensation claimant (Claimant). The Carrier reimbursed less than the billed amount and Vista requested medical dispute resolution before the MRD, which subsequently declined to order any additional payment for the services. The Administrative Law Judge (ALJ) concludes that Vista has failed to show that it is entitled to additional reimbursement.

On June 5, 2007, State Office of Administrative Hearings (SOAH) ALJ Kerry D. Sullivan held a contested case hearing in Austin, Texas. The Carrier appeared at the hearing through its attorney, James M. Loughlin. Vista appeared through its attorney, Cristina Hernandez. The record closed on July 3, 2007, after the parties submitted written closing arguments.

[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. These proceedings 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.

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.[2] 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.[3] 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.

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. 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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[2] 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.

[3] § 413.011(d) of the Act.

(C) a negotiated contract amount.[4]

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.

As the party requesting a hearing before the State Office of Administrative Hearings, Vista has the burden of proof by a preponderance of the evidence.[5]

III. DISCUSSION AND ANALYSIS[6]

The Claimant sustained a work-related injury, the compensability of which is not in dispute. The Claimant received care at a Vista ASC facility. The physician performing the treatments billed the appropriate Carrier, and the physician's 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 physician.

Vista billed the Carrier its usual and customary charges based on a price list referred to as a "Charge Master." The bill totaled $15,183.23 for services associated with an arthroscopy of the knee with meniscectomy. The Carrier reimbursed the sum of $6,326.92. In this matter, Vista seeks additional reimbursement that would provide it a total reimbursement equal to 70% of its billed charges.

In support of its request for additional reimbursement, Vista has presented evidence of

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[4] 28 TAC § 133.1(a)(8).

[5] 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.

[6] This decision largely follows the discussion and analysis set out in another decision relating to reimbursement disputes between Vista and another Carrier, which the ALJ finds persuasive. *Vista Healthcare, Inc. v. Twin City Fire Insurance, Co.*, Docket No. 453-03-0143.M4 (June 12, 2007).

its billing practices and the amount of reimbursement it typically receives from other insurance carriers and governmental bodies for the ASC services it provides. 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 the Carriers in these proceedings. 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.[7] In fact, at least one of Vista's contracts with a health network provided that Vista would be reimbursed at 70% of its billed charges. 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.

The ALJ is not persuaded, however, 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 presented no evidence to address how the fees set out in the Charge Master, from which the bills were all calculated, were established. Its only witness, Jean Wincher, the person in charge of admissions, billing and collections for Vista Healthcare, testified candidly that she did not know how these charges were developed. Ms. Wincher also had no information regarding the extent or duration of the medical services provided in this case.

Even so, the amounts that other Carriers have paid – particularly pursuant to a negotiated contract – may be some indication of what might be a fair and reasonable amount, particularly if a clear pattern could be discerned in the amounts paid. But Vista's documentation was incomplete and unreliable. Vista charged medicare patients a reduced rate from the Charge Master and typically received close to full payment for these patients, thereby skewing the data. There is also a wide variety in the percentage payments made by different Carriers, indicating there was no consensus regarding payment of a particular percentage of the bills. Additionally, there are numerous mistakes in the bills in which the carrier paid more than 100% of the bill, further skewing the data. Finally, no details were provided regarding the contract Vista had at one time with a health network for the payment of 70% of its charges.

[7] 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.

Even if Vista's information were complete and accurate, however, it would not, standing alone, satisfy the statutory guidelines set out in Section 413.011 of the Act for determining fair and reasonable reimbursement. In fact, the Division has previously rejected a "percentage of billed charges" methodology for determining fair and reasonable reimbursement amounts[8] because such a methodology would leave the level of reimbursement under the provider's control and thereby fail to achieve effective medical cost control.

Because Vista bears the burden of proof, the lack of evidence showing the fairness and reasonableness of its charges would be dispositive even in the absence of countervailing evidence by the Carrier. Nevertheless, the Carrier presented substantial information indicating that the Petitioner's bills were not, in fact, fair and reasonable. The amounts charged were shown to exceed the following standards or potential benchmarks for fair and reasonable reimbursement: 1) the Division's *per diem* rate for procedures performed on an inpatient basis; 2) the Medicare payment rate; 3) the rate under the current ASC Fee Guideline; 4) the rates under other states' workers' compensation ASC fee guidelines; and 5) rates established in prior decisions of the Medical Review Division and SOAH.[9]

For the above reasons, Vista is not entitled to additional reimbursement. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

1. The Claimant received care at a Vista ASC facility for a compensable, work-related injury.

2. The Claimant received an arthroscopy of the knee with meniscectomy.

3. Mid-Century Insurance Company is the insurance carrier responsible for the workers' compensation insurance benefits administered to the Claimant.

4. Vista billed the Carrier $15,183.23, which was its usual and customary charge for the services provided to the claimant.

5. The Carrier reimbursed the sum of $6,326.92.

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[8] 22 Tex Reg 6276 (1997).

[9] This countervailing evidence is summarized in Hartford Underwriters Insurance Company's Written Closing Argument, at 21-33.

6. Vista sought additional reimbursement and submitted to the Commission a request for dispute resolution.

7. MRD issued its Findings and Decision, ordering no additional reimbursement by the Carrier.

8. Vista requested a hearing in each docket, and the Commission issued a timely notice of hearing and referred the cases to SOAH 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. On June 5, 2007, SOAH Administrative Law Judge Kerry D. Sullivan held a contested case hearing on this matter in Austin, Texas. Vista appeared through its attorney, Cristina Hernandez. The Carrier appeared through its attorney, James M. Loughlin. The record closed on July 3, 2007, after the parties submitted closing written arguments.

11. Vista sought recovery of 70% of its billed charges as fair and reasonable.

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

13. Vista failed to show that its usual and customary billed charges, or 70% of its billed charges, are fair and reasonable.

V. CONCLUSIONS OF LAW

14. 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.

15. 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. § 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

16. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE (TAC) § 148.3.

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

18. 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).

19. Vista had the burden of proving by a preponderance of the evidence that it was entitled to additional reimbursement. 28 TAC § 148.21(h).

20. 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).

21. 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.

22. A "usual and customary" charge may be the same as a "fair and reasonable" reimbursement amount only if the factors set out in § 413.011 of the Act are satisfied; that is, 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).

23. Vista has 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 ORDERED that Mid-century Insurance Exchange is not required to provide any additional reimbursement for the services in issue in this proceeding.

SIGNED September 4, 2007.

KERRY D. SULLIVAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS