SOAH DOCKET NO. 453-03-0617.M4

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
PACIFIC EMPLOYERS	§	
INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

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 Texas, providing surgical services to patients not requiring in-patient hospitalization. Vista billed Pacific Employers Insurance Company (Carrier) for services provided to a workers' compensation patient. 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. Vista has the burden of proving that it is entitled to additional payment for the services rendered.[2] After considering all of the evidence and arguments, the Administrative Law Judge (ALJ) concludes that Vista has failed to meet its burden; therefore, it is not entitled to any additional reimbursement.

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

[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] Despite Vista's assertion to the contrary, Carrier has no burden of proof in this matter. It is Vista that seeks a higher level of reimbursement than that already approved by MRD. Accordingly, the ALJ will order no additional reimbursement unless Vista shows itself entitled to such.

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
> >
> > (C) a negotiated contract amount.[6]

---

[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 § 134.1(f).

[6] 28 TEX. ADMIN. CODE § 133.1(a)(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 accounts for the factors used by the Commission in setting fee guidelines.

III. DISCUSSION AND ANALYSIS

In this case, the claimant sustained a work-related injury. The compensability of the injury is not in dispute. The claimant received care at a Vista ASC facility. The physician performing the treatment billed Carrier, and the physician's charges are not in dispute in this proceeding; nor is there a dispute about the treatment given. Rather, what is in dispute is the amount billed by Vista for its facility charges associated with the procedure performed by the treating physician.

Vista billed Carrier $6,286.62 for an epidural steroid injection performed on April 25, 2001. Carrier reimbursed Vista $1,118.00. Vista seeks additional reimbursement of $5,168.62.

To support its request for additional reimbursement, Vista presented evidence of 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 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.[7] Based on this evidence, Vista argues that it is entitled additional reimbursement for the services at issue in this docket.

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. Billed charges and historical reimbursement rates, by themselves, do not show

[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. *See* Vista Ex. 8.

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.[8] 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.

In fact, Vista's evidence reflects that reimbursement mistakes were commonly made. On numerous occasions, Vista was reimbursed more than it billed for its ASC services. Because Vista's evidence includes these overpayments, the average reimbursement rate is artificially inflated by them. Vista's data also shows wide variations between the reimbursements by different carriers. While payment data might be indicative of a fair and reasonable amount if it is uniformly consistent, it provides little persuasive value when it shows wide variations in reimbursement amounts.

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 amount sought satisfies these factors and, thus, are fair and reasonable under the Act. Vista's evidence has not established this, so the ALJ cannot conclude that Vista's charges are fair and reasonable in light of the factors identified in Section 413.011.

Further, the ALJ finds relevant the vast discrepancy between what Vista billed for the procedures in issue and the MAR for hospitals during the relevant time periods–which was $1,118.00 a day for a patient's 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.

[8] 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.

Carrier submitted the deposition of Nicholas F. Tsourmas, M.D.,[9] who stated the following:

- Only minor surgeries are performed in ASCs.
- The typical ASC patient is low risk and healthy.
- A typical procedure would involve an hour stay in the operating suite, with another hour of wake-up time and one hour of monitoring.
- The bills generated by ASCs do not include the cost of the surgeon performing the procedure.
- The Commission's 1997 hospital fee guideline reimbursed a hospital $1,118.00 for a single day admission, which Dr. Tsourmas considered fair and reasonable.
- Dr. Tsourmas indicated that the current fee guidelines for ASCs, which are based on the Medicare standard and a multiplier of 213.3 percent, is both reasonable and fair.

Given Dr. Tsourmas' deposition testimony and report, as well as the difference in Medicare billing for same or similar procedures, Vista's billings appear exorbitant, and Vista has not justified them, except to say that the market has been willing to pay those 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) in this case represent a fair and reasonable reimbursement under the applicable legal guidelines, the ALJ concludes that it is not entitled to any 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 Healthcare, Inc. (Vista), ambulatory surgical center (ASC) facility for a compensable, work-related injury.

2. Pacific Employers Insurance Company (Carrier) is the insurance carrier responsible for the workers' compensation insurance benefits administered to the claimant.

3. Vista billed Carrier its usual and customary charges of $6,286.62 for the services provided to the claimant: an epidural steroid injection, performed on April 25, 2001.

[9] Dr. Tsourmas has been practicing as an orthopedic surgeon since 1983 and performs surgeries in hospitals and ASCs. He has performed surgeries in ASCs for approximately nine to ten years. Carrier Ex. 6.

4. Carrier reimbursed Vista $1,118.00.

5. Vista sought additional reimbursement and submitted to the Texas Workers' Compensation Commission (Commission) a request for medical dispute resolution.

6. The Commission's Medical Review Division (MRD) issued its Findings and Decision in this matter, ordering no additional reimbursement by Carrier.

7. Vista requested a hearing, and the Commission issued a timely notice of hearing and referred the case to the State Office of Administrative Hearings (SOAH) for assignment of an Administrative Law Judge (ALJ).

8. 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.

9. On June 18, 2007, SOAH ALJ Sarah G. Ramos held a contested case hearing at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. This proceeding was consolidated for hearing purposes with other dockets involving Vista. Carrier appeared at the hearing through its attorney, Robert F. Josey. Vista appeared through its attorneys, William Eric Carter and Christina Y. Hernandez. The record closed on July 2, 2007, after the parties submitted written closing arguments.

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

V. CONCLUSIONS OF LAW

1. The 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.

2. 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.

3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

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

5. 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).

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

7. Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates, until such time that specific guidelines are established by the Commission. 28 TEX. ADMIN. CODE § 134.1(f).

8. 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.

9. A "usual and customary" charge constitutes "fair and reasonable" reimbursement amount only if the factors set out in § 413.011 of the Act are shown to be 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 TEX. ADMIN. CODE § 133.1(a)(8).

10. Vista failed to show that its usual and customary billed charges–or even 70% of its billed charges, which is the amount it seeks in this proceeding–are fair and reasonable.

11. Vista 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 order of the Medical Review Division of the Texas Workers' Compensation Commission in the underlying case, **IT IS, THEREFORE, ORDERED** that Pacific Employers Insurance Company is not required to provide any additional reimbursement for the services in issue in this proceeding.

SIGNED August 28, 2007.

SARAH G. RAMOS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS