SOAH DOCKET NO. 453-03-3903.M4
TWCC MRD NO. M4-02-3761-01

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	
	§	**OF**
BANKERS STANDARD INSURANCE	§	
COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Vista Healthcare, Inc. (Vista) contested a decision by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) denying additional payment for ambulatory surgical center (ASC) services.[1] Until November 2002, Vista operated an ASC in Houston, Texas. ASCs provide surgical support services to patients not requiring hospitalization. In this case, Vista billed Bankers Standard Insurance Company (Carrier) for services associated with the placement of temporary spinal cord stimulator leads in the spine of _____ (Claimant) on June 18, 2001. Because Carrier reimbursed Vista $14,296.00, significantly less than Vista's $23,118.03 billed charges, Vista requested medical dispute resolution before the MRD. The MRD declined to order any additional payment for the services rendered. In this proceeding, Vista seeks 70 percent of the billed charges.

After considering all of the evidence and arguments, the Administrative Law Judge (ALJ) concludes that Vista has failed to meet its burden of proof to show that it is 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. For clarity, "the Commission" shall be used throughout. The referenced agency case number is the cause number before the Commission's MRD.

The hearing in this matter convened on July 16, 2007, in Austin, Texas, with ALJ Carol Wood presiding. The record closed on August 10, 2007, upon receipt of the parties' briefs and supporting opinions. Attorney James M. Loughlin represented Carrier and attorney Cristina Hernandez represented Vista.

I. APPLICABLE LAW

A. Statutes and Rules

This case is governed by the Texas Workers' Compensation Act (the Act).[2] 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.[3]

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.[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 also must be considered.

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

[3] TEX. LAB. CODE § 401.011(19) and (31). Unless otherwise noted, all cites to statutes and rules are to those in effect in 2001.

[4] TEX. LAB. CODE § 413.011(b).

In 2001, the Commission had not yet adopted payment guidelines for ASC services. Pursuant to Commission rule, an insurance carrier, in reimbursing providers for services without a fee guideline in place, was required to reimburse for those services at a fair and reasonable rate, as described in Section 413.011(b) of the Act.[5] Section 133.1(a) (8) of Commission rules defines "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
>
> (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.

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 that ensures the quality of medical care and takes into account all factors the Commission must use in setting fee guidelines.

B. Burden of Proof

As the party requesting a hearing before the State Office of Administrative Hearings (SOAH), Vista has the burden of proof.[6] That burden of proof is by preponderance of the evidence.

[5] 28 TEX. ADMIN. CODE § 134.1(f).

[6] 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.

II. DISCUSSION

A. Summary of Claim

On June 18, 2001, a surgeon placed temporary spinal cord stimulator leads into Claimant's epidural space for a spinal cord stimulation trial (CPT Code 63610; Medicare ASC Group 1). No complications arose in the treatment of Claimant, who was in surgery approximately 65 minutes and in the recovery room approximately 75 minutes.[7] The ASC provided the surgical facility, supplies, medications, and other support functions for the physician performing the procedure.

Vista billed Carrier $23,118.03. Carrier, however, reimbursed Vista $14,296.00, and Vista requested medical dispute resolution before the MRD. On April 18, 2003, the MRD issued an order denying additional reimbursement to Vista on the basis that Vista had failed to demonstrate that its billed charges constituted fair and reasonable reimbursement under the Commission's statutes and rules.

B. Basis for Billed and Reimbursed Amounts

Vista asserts it is entitled to reimbursement from Carrier of 70 percent of its billed charges. Vista argues that, because it historically had received 70 percent of its billed charges from many insurance carriers, that amount represents fair and reasonable compensation.

In establishing its payment history, Vista relied on the testimony of Jean Wincher, Vista's administrator in 2001, who oversaw admissions, billing, and collections. Ms. Wincher testified she did not participate in setting Vista's policies or practices on billing. She explained that, for the most part, Vista compared payments received from a variety of its payors, including payors reimbursing under negotiated contracts, and billed Carrier amounts similar to those payments. Vista argues its reliance on that information is well founded because this is the type of information that MRD considered in the past and continues to describe as persuasive in determining fair and reasonable reimbursement.

[7] Ex. VHI 9.

Vista received payment of its billed charges at varying levels. A table of payments presented by Vista showed that, in 2001, Vista received payments from a variety of payors and those payments varied from one percent to 100 percent of its billed charges. In other words, payment of 70 percent of billed charges was not a universal practice in the industry. Vista also cited agreements it had with FOCUS Healthcare Management for the FOCUS PPO network and with Preferred Health Network that paid 70 percent of billed charges.

However, Vista presented no evidence demonstrating that its determination to rely on the reimbursement amounts paid by other payors as a basis for setting billing charges for workers' compensation claims in Texas was based on an analysis of any of the factors set forth in the Act.

Nor did Vista provide evidence that, when developing its billing charges, it consulted any national guidelines or norms for either ASCs or workers' compensation claims.

Carrier argues that the amount sought by Vista is grossly excessive and does not meet the statutory standards for reimbursement, while the amount paid by Carrier meets or exceeds the statutory standards for fair and reasonable reimbursement. Carrier notes that it reimbursed Vista $14,296.00, which represents payment of $2,236.00 for the ASC facility charges, the equivalent of two inpatient surgical days under the Commission's Acute Care Inpatient Hospital Fee Guideline (Fee Guideline),[8] plus reimbursement of $12,060.00 for the spinal cord stimulator leads. Carrier asserts that $2,236.00 is certainly appropriate reimbursement of facility charges for a procedure performed in an ASC with a length of stay significantly less than 24 hours.[9]

Additionally, Carrier points out that, under the Fee Guideline, an acute care hospital would have been entitled to reimbursement for surgical implants at cost plus 10 percent. Vista charged Carrier $12,060.00 for the stimulator leads.[10] Ms. Wincher testified that the mark-up on Vista's

[8] 28 TAC § 134.401 (eff. Aug. 1, 1997).

[9] Claimant was at Vista's facility less than 4 hours. (Ex. VHI 9).

[10] Id.

implants was 400 percent; thus, Vista's cost for the leads was $3,015.00. Carrier argues that cost plus 10 percent equals $3,316.50; therefore, Carrier reimbursed Vista $8,743.50 more than would have been allowed for the leads under the Fee Guideline.

Carrier asserts that reimbursement to Vista under the Fee Guideline would have been $1,118.00 plus $3,316.50 for the leads, for a total reimbursement of $4,434.50. For this reason, Carrier argues that the amount sought by Vista is $11,762.12 more than the amount of reimbursement that would have been paid if the surgery had been performed in a hospital with a one-day inpatient stay. Carrier contends that, because of this overpayment, Vista has already been paid more than a fair and reasonable amount for its ASC services in this case.

C. Analysis

Vista's theory of reimbursement based on rates derived from a general comparison with other payors' reimbursement rates assume that the reimbursement rates of Vista's other payors were themselves consistent with the criteria in the Act and the rules. However, Vista's reliance on data from other payors is misplaced because the record is silent as to why the other payors agreed to pay Vista the amounts they did. There is no evidence that Vista inquired into the reasons for the reimbursement amounts 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.

Further, the large variance in payment levels received by Vista from other payors, ranging from one percent to 100 percent of billed charges, undermines Vista's assertion that reimbursement of 70 percent of billed charges was a standard industry practice in 2001. Vista's comparison data show only that it billed Carrier what can be characterized as its usual and customary rate. However, a provider merely billing a workers' compensation carrier its usual and customary rate does not meet the requirements for appropriate billing set forth in Section 413.011(b) of the Act. Because Vista failed to demonstrate that its billing structure took into account the statutory requirements for appropriate billing for workers' compensation claimants, Vista failed to provide any credible evidence to show that the rates it billed Carrier met

the statutory criteria. Vista, therefore, failed to meet its burden of proof.

D. Summary

As Vista failed meet its burden of proof to show that 70 percent of its billed charges met the criteria for fair and reasonable reimbursement set forth in § 413.011 of the Act, the ALJ concludes that no additional reimbursement from Carrier is warranted.

III. FINDINGS OF FACT

1. ASCs provide the surgical facility, supplies, medications, and other support functions for physicians performing surgical procedures. All ASC procedures are administered on an outpatient basis.

2. On June 18, 2001, Vista provided ASC services for the placement of temporary spinal cord stimulator leads in the epidural space of a workers' compensation claimant.

3. The services in this case were free of medical complications and involved a stay of less than 4 hours at Vista's ASC.

4. Carrier was the responsible insurer for Claimant in 2001.

5. Vista submitted bills to Carrier in the amount of $23,118.03 for services that Vista had provided Claimant.

6. Carrier reimbursed Vista $14,296.00.

7. Reimbursement to Vista under the Commission's Acute Care Inpatient Hospital Fee Guideline would have been $1,118.00 plus $3,316.50 for the leads, for a total reimbursement of $4,434.50.

8. The amount sought by Vista in this case is $11,762.12 more than the amount of reimbursement that would have been paid if the surgery had been performed in a hospital with a one-day inpatient stay.

9. Vista developed its billing charges to Carrier based on billing charges made to and paid by other payors to Vista under managed-care contracts and other fee arrangements.

10. Vista did not evaluate its billing charges to determine whether those charges ensured the quality of medical care for workers' compensation claimants, achieved effective medical cost control, or were comparable to fees charged for similar treatment of an injured individual of

an equivalent standard of living.

11. Vista did not evaluate its billing charges in light of any national guidelines or norms for either ASCs or workers' compensation claims.

12. Vista received payment for its billed charges from other payors at varying rates and did not consistently receive payment of 70 percent of its billed charges from other payors.

13. In 2001, there was no medical fee guideline in place for ASC services.

14. Vista protested the reimbursement paid by Carrier and timely sought a hearing before the Commission's MRD to consider whether Vista should receive reimbursement of 70 percent of its billed charges.

15. In a decision issued on April 18, 2003, the MRD determined that Vista had failed to demonstrate that the rates it charged were fair and reasonable and so concluded that Vista was due no additional reimbursement from Carrier.

16. Vista timely requested a contested case hearing on the MRD decision.

17. The Commission issued a notice of hearing that included the date, time, and location of the hearing; the applicable statutes under which the hearing would be conducted; and a short, plain statement of matters asserted.

18. ALJ Carol Wood conducted a hearing on the merits on July 16, 2007, and the record closed August 10, 2007, when the parties filed their post-hearing briefs and supporting cases.

IV. CONCLUSIONS OF LAW

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

2. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE § 401.031 and TEX. GOV'T CODE ch. 2003.

3. Vista's request for hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE §§ 2001.051 and 2001.052.

5. Vista has the burden of proof by a preponderance of the evidence in this proceeding, pursuant to 28 TEX. ADMIN CODE § 148.14.

6. The services Vista provided to Claimant in this case comprised health care reasonably required and medically necessary to treat Claimant's compensable injury, within the meaning of TEX. LAB. CODE § 408.021(a) (1).

7. The services Vista provided to Claimant were not covered by a fee guideline issued by the Commission, and so were required to be billed and reimbursed at a fair and reasonable rate within the meaning of TEX. LAB. CODE § 413.011.

8. Vista failed to prove that 70 percent of its usual and customary charges that it billed for the procedure at issue constituted fair and reasonable reimbursement within the meaning of TEX. LAB. CODE § 413.011.

9. Vista 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 THEREFORE, ORDERED that Bankers Standard Insurance Company is not required to pay any additional reimbursement to Vista Healthcare, Inc., for the ASC services Vista provided to workers' compensation claimant _____ in this proceeding.

SIGNED October 9, 2007.

_____

CAROL WOOD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS