SOAH DOCKET NO. 453-03-0502.M4
SOAH DOCKET NO. 453-03-3961.M4
SOAH DOCKET NO. 453-03-3962.M4
SOAH DOCKET NO. 453-03-1532.M4
SOAH DOCKET NO. 453-03-1533.M4

VISTA HEALTHCARE, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
ZNAT INSURANCE CO.,	§	
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)[1] denying additional payment for ambulatory surgical center services. Vista[2] operated ambulatory surgical centers (ASCs) that provided outpatient surgical services to patients not requiring hospitalization. Vista billed ZNAT Insurance Company (Carrier)[3] for services provided to five different claimants in 2001.[4] Carrier reimbursed less than the billed amount, and Vista requested medical dispute resolution before MRD, which declined to order any additional payment for the services. In this proceeding, Vista has the burden of proving that it is entitled to additional payment for the services provided. After considering all of the evidence and arguments, the Administrative Law Judge (ALJ) concludes that Vista failed to meet its burden and is, therefore, not entitled to any additional reimbursement.

II. APPLICABLE LAW

The Texas Workers' Compensation Act (the Act) is found at TEX. LAB. CODE ANN. §

[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.

[2] Two Vista entities are represented in this proceeding: Vista Healthcare, Inc., which operated an ASC in Pasadena and Vista Surgical Center, which operated an ASC in Houston.

[3] Also known as Zenith Insurance Company.

[4] Because the cases were heard together, the ALJ is issuing a single decision in the five above-captioned cases.

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.[5] 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.[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 must be considered.

During the time period relevant to this proceeding, however, the Commission had not established a fee payment guideline for ASC services. In such a situation, reimbursement for such services was to be provided at a fair and reasonable rate as described in Section 413.011(d) of the Act.[7] 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.[8]

[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—during the relevant time periods at issue in this case.

[6] § 413.011(d) of the Act.

[7] 28 TAC § 134.1(f).

[8] 28 TAC § 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 amount that ensures the quality of medical care and accounts for the factors used by the Commission in setting fee guidelines. Vista had the initial burden of providing "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement."[9]

III. DISCUSSION AND ANALYSIS

In each of the five cases at issue, the claimant sustained a work-related injury. The claimants all received care at a Vista ASC facility. The compensability of the injuries is not in dispute. The physicians' charges are not in dispute; nor is there a dispute about the treatments given. The amounts billed by Vista for its facility charges associated with the procedures performed by the treating physicians are in dispute.

In each of the cases, Vista billed Carrier its usual and customary charges, ranging from $4,277.07 to $17,586.89, depending on the procedure performed. Carrier's reimbursements ranged from $2,098.67 to $3,123.20. Vista is seeking additional reimbursement that would provide it with a total reimbursement equal to 70% of its billed charges.

A. Contract

Vista presented evidence and the testimony of Jean Wincher,[10] an administrator for Vista, that because Carrier was a member of a contracting network, it was bound by contract to reimburse 70% of Vista's billed charges. The contract itself was not offered as evidence,

[9] 28 TAC § 133.305(e)(1)(F).

[10] Ms. Wincher is employed by Doctors' Practice Management where she is responsible for billing, collections, medical dispute resolutions, and processing of admissions on behalf of Vista and other health care providers.

however, and the documents that were admitted into the record did not clearly establish that ZNAT Insurance Company was a party to the contract. The contract at issue was entered into by a third-party administrator--Preferred Health Network, which later became a subsidiary of FOCUS--on behalf of numerous carriers and self-insured employers. Two FOCUS client lists dated April 5 and October 3, 2002, list a company referred to as "The Zenith." Arguably it is the same company as ZNAT Insurance Company, but 2002 was after the dates of service in question and the term "client" is not defined.[11] Ms. Wincher's testimony added little additional insight into the issue, although she may have negotiated a contract with FOCUS. Furthermore, two EOB references indicating that two items were being reimbursed based on a negotiated contract is not strong evidence of the existence of a contract with Vista, except for those two services alone.[12] The ALJ, therefore, does not find that the evidence presented is sufficient to show that the disputed reimbursements in these cases were controlled by negotiated contract amounts.

B. Reimbursements Received

In support of its request for additional reimbursement, Vista also presented evidence in the form of a spreadsheet of its billing practices and the amount of reimbursement it typically received from other insurance carriers and governmental bodies for the ASC services it provided. Vista argues that it is entitled to additional reimbursement because it has historically received a level of reimbursement from other insurance companies that is higher than that offered by Carrier in those cases. According to the spreadsheet, Vista's average reimbursement rate was approximately 60% of the billed charges. Further, its median reimbursement rate was 70% of billed charges.[13] In other words, one-half of all procedures were reimbursed at higher than 70% of billed charges, while one-half were reimbursed at less than 70% of 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 cases.

[11] Vista Ex. 8 at VHI 55-56, Docket No. 453-05-1533.M4.
[12] Vista Ex. 4 at VHI 26, 31, Docket No. 453-05-1533.M4.

The ALJ is not persuaded, however, that the evidence presented of Vista's 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, including the contract percentage discussed above, by themselves, do not show compliance with the factors identified in Section 413.011 of the Act for determining a fair and reasonable reimbursement. For one thing no evidence was presented showing that the billed charges were reasonably based. Ms. Wincher's testimony only mentioned that supplies were marked up five times and implants were marked up four times. And although the amounts that other carriers have paid, including those paid pursuant to a contract, may be some indication of what might be a fair and reasonable amount, by itself that information is not dispositive. There can be many reasons why a carrier might reimburse at a rate higher than what would be reasonable, including mistakes.

Vista's spreadsheet reflects a number of reimbursement mistakes, including those over 100%. In one such instance a carrier paid 170% of the billed charges.[14] Although the carriers were reimbursed for the overpayments, the calculation was not changed and the average and median reimbursement percentages are, therefore, artificially inflated. Additionally, Ms. Wincher acknowledged that Vista routinely billed Medicare pursuant to the Medicare guideline in effect at that time since it knew what the amount of those reimbursements would be. *See, e.g.,* Vista Ex. 10, at 9, ln. 333, Docket No. 453-05-1533.M4, showing reimbursement at 104% for the billed charges of $614.24. That practice served to artificially inflate the average and median reimbursement percentages. Notably, Vista billed a carrier $5,324.87 for the same service.[15]

Furthermore, that a number of carriers were willing to reimburse Vista at 70% of its billed charges is not indicative of fair and reasonable reimbursement because it does not achieve effective cost control pursuant to Section 413.011 of the Act. The Commission has previously

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[13] Vista Ex. 10 at 51, Docket No. 453-05-1533.M4.

[14] Vista Ex. 10 at 2, ln. 42, Docket No. 453-05-1533.M4. *See also* lns. 52 and 60, showing overpayments of 110% and 129%.

[15] Vista Ex. 10, at 9, ln. 339, Docket No. 453-05-1533.M4.

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. As early as 1997, the Commission rejected reimbursement based on what providers charged because they allowed the providers "to affect their reimbursement by inflating their charges" and rejected the "discount from billed charges" approach, "because it leaves the ultimate reimbursement in the control of the [provider], thus defeating the statutory objective of effective cost control" and "provides no incentive to contain medical costs."[16]

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 it seeks satisfy those factors and, thus, are fair and reasonable under the Act. In this case, Vista's evidence has not established its burden. Its only witness could not identify any of the statutory factors to consider when determining a fair and reasonable reimbursement, and none of its documentary evidence shows how 70% of its billed charges would comply with the statutory factors for determining a fair and reasonable reimbursement. Accordingly, 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 discrepancy between the amounts Vista billed for the procedures at issue and the maximum allowable reimbursement (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 an ASC would be entitled to greater payment than a hospital, Vista has not adequately shown that to be the case here or otherwise 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'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.

[16] 22 Tex. Reg. at 6262, 6268, and 6276 (1997).

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 amount according to 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.[17]

IV. FINDINGS OF FACT

1. Each of the claimants involved in the five cases addressed by this order received outpatient surgical care at a Vista Ambulatory Surgical Center (ASC) facility for their compensable, work-related injuries.

2. ZNAT Insurance Company (Carrier) is the insurance carrier responsible for the workers' compensation insurance benefits administered to each of the claimants.

3. Vista billed Carrier its usual and customary charges for the services provided to each of the five claimants, with those charges ranging from a low of $4,277.07 to a high of $17,586.89, depending on the procedure performed.

4. Carrier reimbursed various amounts in each instance, ranging from a low of $2,098.670, an amount almost twice the maximum allowable reimbursement (MAR) under the hospital fee guideline for a hospital billing for similar services, to $3,238.52.

5. Vista sought additional reimbursement and submitted to the Texas Workers' Compensation Commission (Commission) a request for dispute resolution in each of the five cases.

6. The Commission's Medical Review Division (MRD) issued its Findings and Decision in each of the five cases, ordering no additional reimbursement by Carrier.

7. Vista requested a hearing in each case, and the Commission issued proper notice of hearing and referred the cases to the State Office of Administrative Hearings (SOAH) for

[17] The findings and conclusions apply to each of the cases 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.

assignment of an Administrative Law Judge to hear the disputes.

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 July 30, 2007, SOAH Administrative Law Judge Katherine L. Smith held a contested case hearing concerning the five above-referenced cases at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Carrier appeared at the hearing through its attorney, James Loughlin. Vista appeared through its attorney, Cristina Hernandez. The record closed on August 27, 2007, after the parties submitted closing written arguments.

10. Vista seeks reimbursement in the amount of 70 percent of its billed charges.

11. Vista did not have a managed health care contract with the Carrier that would support reimbursement of 70 percent of billed charges.

12. The willingness of some carriers to pay at or near the billed amount does not establish that the billed amount is fair and reasonable.

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

14. The amount Vista billed the Carrier and the amount it now seeks in reimbursement far exceed the amount of reimbursement that a hospital would receive for the same procedure

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

7. 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).

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 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).

10. A negotiated contract may be the same as a "fair and reasonable" reimbursement amount only if there is evidence of the existence of the contract. 28 TAC § 133.1(a)(8).

11. Vista was required to show that the reimbursement it seeks is fair and reasonable, and its historical billings and reimbursement rates by themselves do not show compliance with the factors identified in Section 413.011 of the Act or the Commission's rules for determining a fair and reasonable reimbursement.

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

13. Vista's charges were excessive.

14. 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 ZNAT Insurance Company is not required to provide any additional reimbursement for the services at issue in the five cases in this proceeding.

SIGNED August 30, 2007.

KATHERINE l. SMITH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS