SOAH DOCKET NOS. 453-05-1493.M4, 453-05-1494.M4, and 453-03-0316.M4
TWCC MRD NOS. M4-03-4386-01, M4-03-3901-01, and M4-02-2466-01

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

DECISION AND ORDER

Vista Healthcare, Inc. (Vista) contested decisions 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 these cases, Vista billed Texas Mutual Insurance Company (Carrier) for services provided to three claimants.[2] Carrier reimbursed Vista for less than the billed amount and Vista requested medical dispute resolution before the MRD. In all three cases, the MRD declined to order any additional payment for the services rendered. The total amount in dispute in these cases is approximately $29,000.00, as outlined in more detail below.

[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 numbers are the cause numbers before the Commission's MRD.

[2] For efficiency and by agreement of the parties, these cases were heard together and evidence received in one that was common to all cases was adopted by reference in other hearings held the same day. With the exception of medical information specific to a claimant's treatment, the evidence in all cases was nearly identical. Therefore, reference will be made on only one exhibit in cases where the exhibits were duplicated in each case.

After considering all of the evidence arguments, the Administrative Law Judge (ALJ) concludes that Vista failed to meet its burden of proof to show that it is entitled to any additional reimbursement in any of the cases presented.

The hearing in this matter convened on May 17, 2007, in Austin, Texas, with Administrative Law Judge (ALJ) Cassandra J. Church presiding. The record closed on June 1, 2007, upon receipt of the parties' briefs. Attorney Brian Jones 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).[3] 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.[4]

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

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

[4] 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 and 2002.

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.[5] 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 and 2002, 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.[6] The then-applicable rule, 28 TEX. ADMIN. CODE § 133.1(a)(8), stated 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.[7]

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"

[5] TEX. LABOR CODE ANN. § 413.011(d).
[6] 28 TEX. ADMIN. CODE § 134.1(f).

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.

Under the Commission's rules, carriers were required to develop and consistently apply a methodology in order to determine fair and reasonable reimbursement for services for which the Commission had not issued a guideline.[8]

B. Burden of Proof

As the party requesting a hearing before the State Office of Administrative Hearings (SOAH), Vista has the burden of proof.[9] That burden of proof is by preponderance of the evidence. However, due to provisions of 28 TEX. ADMIN. CODE § 133.304(i)(1) that require a carrier to develop an appropriate methodology, the ALJ required the Carrier to also make a showing that its payment met the statutory criteria.

II. DISCUSSION

A. Summary of Claims

The claimants in these cases were treated by arthroscopic procedures or by suturing of torn tissue. No complications arose in treatment of any of the three and the stay of each at

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[7] *Compare* 28 TEX. ADMIN. CODE § 134.1(c) - (e).

[8] 28 TEX. ADMIN. CODE § 133.304(i)(1).

[9] 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.

Vista's ASC was half a day or less.[10] The ASC provided the surgical facility, supplies, medications, and other support functions for the physician performing the procedure; the medical services were billed separately.[11]

The specific treatments administered and amounts billed and paid are as follows:

- On April 2, 2002, Claimant ___ was treated for a torn biceps tendon. The tendon was sutured to a soft tissue in the shoulder and a corkscrew anchor placed.[12] Vista billed $17,798.56 and Carrier reimbursed Vista $1,401.80 for the treatment.[13] The difference between the amounts is $16,172.79. The amount at issue is $11,057.19, which is the amount requested, 70 percent of billed charges, less the amount paid by Carrier. Claimant ___ remained at Vista's facility for approximately four hours.

- On March 7, 2002, Claimant _____ was treated with a knee arthroscopy with removal of meniscus tissue.[14] Vista billed $15,235.68 and Carrier reimbursed Vista $1,074.60 for the treatment. The difference between the amounts is $13,644.86. The amount in dispute is $9,646.17, which is the amount requested, 70 percent of billed charges, less the amount paid by Carrier. No implants were used and Claimant ____ remained at Vista's facility for approximately three and one half hours.

[10] Carrier Exh. R-2 (All cases). (Note: Carrier, as the respondent in this case, identified its exhibits by the designation "R.')

[11] *See* Vista Exhs. 3-6 (__. and __.) and Exhs. 3-7 (__.).

[12] Carrier Exh. R-2 (___).

[13] The Medical Review Division (MRD) decision in this case states that Carrier paid $1,018.80 for the procedure. The figure above was the amount in evidence.

[14] Carrier Exh. R-2 (___).

- On February 20, 2001, Claimant ____ was treated with a knee arthroscopy with removal of meniscus tissue.[15] Vista billed $13,980.02 and Carrier reimbursed Vista $970.00 for the treatment. The difference between the amounts is $13,010.02. The amount in dispute is $8,816.04, which is the amount requested, 70 percent of billed charges, less the amount paid by Carrier. No implants were used and Claimant ____ remained at Vista's facility for approximately three and one half hours.

In its review of these cases, the MRD declined to order Carrier to make additional reimbursement to Vista.[16] In each ruling, the MRD determined that Vista was not entitled to additional reimbursement above the amounts already remitted by Carrier because Vista 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 asserted that it was entitled to reimbursement from Carrier of 70 percent of its billed charges. Vista also asserted that, as it historically had received 70 percent of its billed charges from many insurance carriers, that amount represented fair and reasonable compensation. As a secondary argument, Vista asserted that beginning in 2001 Carrier had, without explanation, dropped its reimbursement levels substantially. Vista's position in this regard appeared to be that such a change amounted to hardship to Vista or that Carrier had failed in a duty to notify it of the changes.

[15] Carrier Exh. R-2 (__)

[16] The MRD decisions were issued on the following dates: August 13, 2002 (___), May 20, 2004 (___ .), and April 23, 2004 (____).

In establishing its payment history, Vista relied on testimony by Jean Wincher, who was Vista's administrator.[17] She oversaw admissions, billing, and collections for Vista.[18] She did not participate in setting Vista's policies or practices on billing.

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.[19] Supplies and implants were billed at four times the cost to Vista; this charge represented Vista's standard markup practice.[20]

In 2000 and 2001, Vista received payment of its billed charges at varying levels. Vista presented no evidence to show that payment rates from payors other than Carrier changed to a constant percentage in 2002. In other words, payment of 70 percent of billed charges was not a universal practice in the industry.

Vista presented no evidence demonstrating that its determination to rely on the reimbursement paid by other payors as a basis for setting billing rates for workers' compensation claims in Texas was based on analysis of any of the factors set forth in the Act or that, when developing its charges, it consulted any national guidelines or norms for either ASCs or workers' compensation claims.

In regard to changes in Carrier's level of compensation, Ms. Wincher stated that, prior to mid-2001, Carrier had reimbursed Vista substantially more for services than it did in the cases at

[17] In 2001, Ms. Wincher was an employee of Doctors Practice Management, a company that performed administrative services for Vista by contract. Vista Exh. 13 (___), pp. 6-8.

[18] Vista Exh. 13 (___), pp. 17-19.

[19] *See* Vista Exh. 14 (___), (Wincher Deposition Exhs. 3 through 8).

[20] Vista Exh. 14 (___), (Wincher Deposition Exhs. 3 through 8).

issue and that it had reimbursed on a percentage of billed charges. She stated that Carrier had not advised Vista of changes in its practices and also stated that the reasons set forth on Carrier's explanation of benefits (EOBs) did not inform them of the changes. She stated that she had attempted informally, but without success, to get clarification from Commission staff regarding appropriate methods to derive a fair and reasonable rate.

Beginning in July 1999, Carrier paid ASC billings based on Medicare rates.[21] Richard Ball, Carrier's Senior Dispute Analyst, testified that developing a reimbursement method based on Medicare rates was based largely on the Commission's determination, made in 1997, that the Medicare population had a standard of living equivalent to workers' compensation claimants.[22] He also stated that Medicare data was publicly available for comparison, unlike private managed care contract data. He also stated that Carrier determined that reimbursement rates based on Medicare rates would be sufficiently high to provide access to health care at ASCs for claimants covered by Carrier. He stated that Carrier moved to this method for reimbursement for both hospitals and ASCs after the Commission, in 1997, rejected reimbursement methods based on a percentage of billed charges for hospitals.[23] Mr. Ball, who is a registered nurse, stated that the types of procedures performed in ASCs could also be performed in a hospital.

Mr. Ball acknowledged that the early months of implementation of Carrier's new system had resulted in some errors, *i.e.*, claims paid under Carrier's prior reimbursement method, but that most claims were properly paid, based on his review of Carrier's payment records.

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[21] Carrier paid service providers 100 percent of the base payment set for Medicare patients for the same or a similar procedure, per the Medicare ASC Groups, and also 20 percent of the median charge weighted by total volume per a rate survey prepared by Health Care Financing Administration, the HCFA *Ambulatory Surgical Centers 1994 Medicare Payment Rate Survey*. Carrier Exh. R-1 (All cases).

[22] The Commission determination regarding the equivalency was made in connection with the implementation of a hospital fee guideline. Carrier Exh. R-7.

[23] Carrier Exhs. R-1 and R-5, pp. 201-206.

The EOBs that Carrier issued to Vista regarding reimbursement in these cases stated that Carrier was paying a reduced amount because it considered Vista's charges not to be fair and reasonable and stated that Carrier would reimburse Vista for an amount that it considered met the criteria in Section 413.011(b).[24] Much lengthier explanations of Carrier's approach were provided to Vista in the course of the dispute resolution process before the MRD, which included references to the various public information sources and rules Carrier had relied on in developing its payment methodology.[25]

C. Analysis

Vista's theory of reimbursement based on charges derived from a general comparison with other payors contains the unstated assumption that the reimbursement rates of Vista's other payors are themselves consistent with the criteria in the Act and rules, and thus are reliable.[26] However, 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. 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.

The variance in payment levels received by Vista also calls into question Vista's assertion that 70 percent of billed charges was a standard industry practice in 2001 and 2002.

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[24] Carrier Exh. R-3 (All cases).

[25] Vista Exh. 8 (__).

[26] Although not dispositive of this case, there was some evidence in the record that tended to corroborate the appropriateness of Carrier's reimbursement methodology. In adopting an ASC fee guideline in 2004, the Commission adopted a system which used Medicare rates as a baseline. Resp. Exh. R-9 (___), Preamble, 28 TEX. ADMIN. CODE § 134.402, 29 Tex. Reg. 4191-4223 (April 30, 2004).

Vista's comparison data demonstrated only that it billed Carrier what can be characterized as its usual and customary rate. However, merely billing a workers' compensation carrier its usual and customary rate does not meet the requirements set forth in Section 413.011(d) of the Act for appropriate billing. Since Vista presented no evidence that it developed a billing structure that took account of the state's requirements for rates for reimbursing workers' compensation providers, Vista failed to provide any credible evidence to show that the rates they billed Carrier met the statutory criteria. Therefore, Vista failed to meet its burden of proof.

Vista's secondary arguments, that Carrier's reduction of its rate of reimbursement constituted a hardship, is irrelevant to resolving the issues in this case. Vista was unable to point to any authority for its position that Carrier was constrained from evaluating its reimbursement practices and then changing them. Carrier's only legal obligations appear to have been to develop and apply a reimbursement formula meeting the criteria in the Act. The EOBs and documents filed as part of the dispute resolution before the Commission identified the grounds for Carrier's reduced payment. Further, Vista appears to have waived any argument concerning Carrier's failure to notify them of the change, if, indeed, a duty to notify existed, because it failed to raise that argument before the MRD.

D. Summary

As Vista failed to meet its burden of proof to show that its billed charges, or some percentage 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 is warranted for any of the cases heard in this combined docket.

III. FINDINGS OF FACT

1. On April 2, 2002, Vista Healthcare, Inc. (Vista), provided ambulatory surgical center (ASC) services for administration of treatment to Claimant ___. for a torn biceps tendon. The tendon was sutured to soft tissue in the shoulder and a corkscrew anchor placed.

2. On March 7, 2002, Vista provided ASC services for administration of a knee arthroscopy procedure to Claimant ____. No implants were used.

3. On February 20, 2001, Vista provided ASC services for administration of a knee arthroscopy procedure to Claimant ___. No implants were used.

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

5. All treatments in Findings of Fact Nos. 1 through 3 above involved stays at Vista's ASC of a half day or less and were free of medical complications.

6. Texas Mutual Insurance Company (Carrier) was the responsible insurer for all three claimants.

7. Vista billed Carrier for services for Claimant ___. in the amount of $17,798.56 (Vista's charges).

8. Vista submitted bills to Carrier for services for Claimant ____. in the amount of $15,235.68 (Vista's charges).

9. Vista submitted bills to Carrier for services for Claimant ___. in the amount of $13,980.02 (Vista's charges).

10. Carrier reimbursed Vista for the procedures as follows: $1,401.80 for Claimant ___.; $1,074.60 for Claimant ___.; and, $970.00 for Claimant ___ (reimbursement amounts).

11. Carrier concluded that the reimbursement amounts constituted fair and reasonable reimbursement for the services rendered under the reimbursement method it employed in 2001 and 2002.

12. Vista developed its charges to Carrier based on charges made to and paid by other insurance providers to it under managed care contracts and other fee arrangements.

13. Vista's standard markup for supplies was four times cost and Vista billed Carrier for supplies at that rate.

14. Vista did not evaluate its billing rate to determine whether those rates insured 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.

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

16. Vista received payment from other payors at varying percentages of its billed charges; Vista did not consistently receive payment of 70 percent of its billed charges in 2001 and 2002.

17. In 2001 and 2002, there was no medical fee guideline in place for ASC services.

18. Before July 1999, Carrier reimbursed claims for ASCs and other medical services at a percentage of billed charges.

19. In July 1999, Carrier implemented a new reimbursement method that was based on Medicare rates and did not involve payment of a percentage of billed charges.

20. In 2001 and 2002, Carrier paid ASCs 100 percent of the base payment set by Medicare for the same or an equivalent procedure, plus 20 percent of the median charge, weighted by total volume, per the *Ambulatory Surgical Center Centers 1994 Medicare Payment Rate Survey,* issued by the Health Care Financing Administration.

21. The amounts Carrier reimbursed Vista for the services listed in Findings of Facts Nos. 1 through 3 were calculated under the Medicare-based reimbursement formula it initiated in 1999.

22. Vista protested the reimbursement paid by Carrier and timely sought a hearing before the Medical Review Division (MRD) of the Texas Workers' Compensation Commission

(Commission) to consider whether it should receive reimbursement of 70 percent of its billed charges.

23. In decisions issued on August 13, 2002 (___.), on April 23, 2004 (__.), and on May 20, 2004 (____.), the MRD determined that Vista had failed to demonstrate that the rates it charged were fair and reasonable and so concluded that no additional reimbursement was due to Vista.

24. Vista timely requested a contested case hearing on all three MRD decisions.

25. In each case, the Commission issued notices 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.

26. Administrative Law Judge Cassandra J. Church conducted a hearing on the merits on May 17, 2007 and the record closed June 1, 2007, to receive briefing by the parties.

27. By agreement of the parties, testimony and other evidence received at other hearings on May 17, 2007, were incorporated and included for all purposes in the record of all hearings conducted on that date.

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. LABOR CODE ANN. § 413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. § 401.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

3. In each case in issue in this proceeding, the 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 ANN. §§ 2001.051 and 2001.052.

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

6. The services provided to the claimants in these cases comprised health care reasonably required and medically necessary to treat Claimants' compensable injury, within the meaning of TEX. LABOR CODE ANN. § 408.021(a)(1).

7. The services provided to claimants 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. LABOR CODE ANN. § 413.011.

8. Vista failed to prove that either that its usual and customary charges, which it billed for the procedures at issue, or 70 percent of its usual and customary charges, constituted fair and reasonable reimbursement, within the meaning of TEX. LABOR CODE ANN. § 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 Texas Mutual Insurance Company is not required to provide any additional reimbursement to Vista Healthcare, Inc., for ASC services provided to workers' compensation claimants in the three dockets in this proceeding.

SIGNED September 7, 2007.

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CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS