SOAH DOCKET NO. 453-02-3655.M4
DWC NO. M4-02-1789-01

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

DECISION AND ORDER

Vista Healthcare, Inc. (Vista) challenges the denial of additional reimbursement by Texas Mutual Insurance Co. (TMIC) for a knee surgery (CPT Code 29870) provided to an injured worker on January 24, 2001, at Vista's ambulatory surgical center (ASC). The Administrative Law Judge (ALJ) finds that the fair and reasonable reimbursement for Vista's services rendered in connection with the knee surgery is $1,221.00.[1] Accordingly, Vista's request for additional reimbursement is denied.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no issues of notice or jurisdiction. Therefore, these matters are addressed in the Findings of Fact and Conclusions of Law without further discussion.

[1] The physician's services were billed separately and are not at issue in this proceeding.

Vista filed a request for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division).[2] On May 29, 2002, the Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision), denying Vista any additional reimbursement. By letter dated June 24, 2002, Vista requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination. A hearing convened before ALJ Thomas H. Walston on March 27, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Christina Hernandez. TMIC was represented by attorney Lauren Damen. By agreement of the parties, the transcripts from SOAH Docket Nos. 453-03-0330.M4 (including TMIC Exhibits 9-15) and 453-03-0306.M4 were incorporated by reference into the record of this case. The record closed on May 29, 2012, when the parties filed their closing briefs.

II. DISCUSSION

A. Applicable Law

This case is governed by the Tex. Lab. Code (Labor Code) § 401.001*et seq.*, also known as the Texas Workers' Compensation Act (Act). The workers' compensation insurance program created by the Act covers all medically necessary health care.[3] Although amended several times, Section 413.011 of the Act generally directs the Division's Commissioner 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.[4] The Act has consistently required that the fee guidelines for medical services

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[2] Effective September 1, 2005, the legislature dissolved the Texas Workers' Compensation Commission (Commission) and created the Division of Workers' Compensation within the Texas Department of Insurance. Act of June 1, 2005, 79th Leg., R.S., ch. 265, § 8.001, 2005 Tex. Gen. Laws 469, 607. This Decision and Order refers to the Commission and its successor collectively as the Division.

[3] Tex. Lab. Code § 401.011.

[4] This section of the Act has been amended on several occasions as follows:

> Acts 1993, 73rd Leg. ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 2001, 77th Leg., ch. 1456, Sec. 6.02, eff. Jun. 17, 2001; Acts 2003, 78th Leg., ch. 962, Sec. 1, 2, eff. Jun. 20, 2003.
> Amended by:
> Acts 2005, 79th Leg., ch. 265, Sec. 3.233, eff. Sept. 1, 2005.
> Acts 2007, 80th Leg. R.S., ch. 1177, Sec. 2, eff. Sept. 1, 2007.
> Acts 2007, 80th Leg., R.S. ch. 1177, Sec. 2, eff. Jan. 1, 2011.

be fair and reasonable, ensure quality medical care, and 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.[6] In setting such guidelines, the increased security of payment afforded by the Act also must be considered.[7]

Prior to May 9, 2004, the Division did not have a fee guideline for medical services provided in an ASC.[8] In reimbursing providers for services without a fee guideline, an insurance carrier is required to reimburse at a fair and reasonable rate, as described in Section 413.011(d) of the Act.[9] At the time the services at issue were provided, "fair and reasonable reimbursement" was defined 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.[10]

Effective May 2, 2006, the Division defined "fair and reasonable reimbursement" as reimbursement that:

> (1) is consistent with the criteria of Labor Code § 413.011;
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> (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and
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> (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.[11]

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[5] Tex. Lab. Code § 413.011(d).

[6] Tex. Lab. Code § 413.011(d).

[7] Tex. Lab. Code § 413.011(d).

[8] Effective May 9, 2004, the Division adopted a fee guideline for ASC services. 28 TAC § 134.402. By its terms, that fee guideline applies only to ASC services provided on or after September 1, 2004.

[9] 28 Tex. Admin. Code § 134.1(f) from Oct. 7, 1991 until May 16, 2002, when it became 28 TAC § 134.1(c). On May 2, 2006, it became 28 TAC § 134.1(c)(3). On March 1, 2008 it was amended to become 28 TAC § 134.1(e)(3).

[10] 28 TAC § 133.1(8).

When the Division has not established a fee guideline for a particular procedure, service, or item, the reimbursement amount is to be determined using the statutory factors. Under the Commission's rules, carriers are required to develop and consistently apply a methodology to determine fair and reasonable reimbursement for services for which the Commission has not adopted a guideline.[12]

B. Burden of Proof

As the party requesting a hearing before the State Office of Administrative Hearings (SOAH), Vista had the burden of proof by preponderance of the evidence.[13] However, due to provisions of 28 TAC § 133.304(i)(1) and 28 TAC § 134.1(g) that require a carrier to develop an appropriate reimbursement methodology, the ALJ also required TMIC to make a showing that its payment met the statutory criteria. [14]

C. Discussion

The MRD Decision found that Vista did not establish the amount it requested was fair and reasonable. At the MRD, Vista sought recovery based on a percentage of its charges being considered as fair and reasonable reimbursement. At the SOAH hearing, Vista altered its theory and requested recovery based on the average of 16 payments it received from multiple payers for services it provided during 2001 in connection with arthroscopic knee surgery under CPT Code 29870.[15] These payments averaged $6,027.82, which Vista asserted is a fair and reasonable charge. To support this position, Vista cited two recent Division medical fee dispute resolution decisions involving Renaissance Hospital. In those cases, the Division found that the average payment by all insurance carriers in the Texas workers' compensation system during the same year and involving

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[11] 28 TAC § 134.1(d)(1)-(3).

[12] 28 TAC § 133.304(i)(1) (eff. July 15, 2000); 28 TAC § 134.1(e) (eff. May 2, 2006).

[13] 1 TAC § 155.427 (eff. Nov. 26, 2008); 28 TAC § 148.21(h) - (i) (eff. Dec. 4, 1995); 28 TAC § 148.14(a) (eff. June 9, 2005).

[14] 28 TAC § 133.304(i)(1) (eff. July 15, 2000); 28 TAC § 134.1(e) (eff. May 2, 2006; amended Mar. 1, 2008).

[15] Vista Ex. 14.

the same procedures that Renaissance provided was the best evidence in those cases of an amount that would achieve a fair and reasonable reimbursement.[16] Vista also argued that TMIC's methodology for determining fair and reasonable reimbursement was defective because TMIC relied in part on Medicare reimbursement rates set in 1998, even though those Medicare rates had been revised by 2001 when Vista provided its services. Therefore, Vista contended that $6,027.82 is a fair and reasonable charge for the services at issue.[17]

In response, TMIC argued that Vista's methodology was flawed because Vista offered no evidence that the payments it received for knee surgery services during 2001 were based on the criteria for fair and reasonable reimbursement established in the Act and the Division's rules. TMIC pointed out that the payments varied widely from $716 to $11,613, and it argued that several payments would not qualify as fair and reasonable because they were based on a percentage of billed charges, which is an impermissible methodology. TMIC disagreed with the decisions rendered in the Renaissance Hospital cases. But even if they are accepted, TMIC stressed, the methodology in those cases averaged payments for the entire workers' compensation system, whereas Vista only averaged payments it received.[18]

TMIC also asserted that the amount it paid Vista was fair and reasonable reimbursement under the applicable standards. In response to Vista's complaint about using 1998 Medicare reimbursement rates, TMIC presented evidence that Medicare rates for knee surgery increased between 1998 and 2001 by only a small amount, and that its reimbursement of $1,221.00 was well above the 2001 Medicare reimbursement rate of $600.41. TMIC also offered evidence, including testimony from Mr. Richard Ball, that its payments ensured access to care; achieved effective medical cost control; did not did not exceed amounts paid on behalf of persons with an equivalent standard of living; and considered the security of payment afforded by the workers' compensation system. TMIC added that its payments were based on assigned values for services involving similar work and resource commitments, and its methodology has been approved by outside experts and in

[16] Vista Exs. 8 and 9; MFDR Tracking Nos. M4-08-2454-01 and MR-08-0446-01.

[17] Vista's post-trial brief.

[18] TMIC post trial brief at 12-29; TMIC reply brief at 2-5.

prior cases. Therefore, TMIC argued, its payment to Vista and its payment methodology were appropriate.[19]

Because Vista presented evidence only of payments it received from various payers, its theory of recovery was not fully consistent with the Division's decisions in the two Renaissance cases, as TMI pointed out.[20] Also, Vista presented no evidence about why the carriers and other payers reimbursed Vista the amounts they did or that those payments were based on the applicable criteria for fair and reasonable reimbursement. In short, Vista failed to establish how its proposed reimbursement level of $6,027.82 complied with criteria contained in the Act and rules for fair and reasonable reimbursement. Therefore, Vista did not meet its burden of proof.

In contrast, TMIC presented specific evidence about how its methodology and its reimbursement amount did meet the applicable criteria. It also effectively addressed Vista's question about using the 1998 Medicare reimbursement rates to establish its reimbursement rates for 2001 by showing that the increase was negligible and that its reimbursement was well above even the revised Medicare rates. Therefore, TMIC established that its payment to Vista was a fair and reasonable reimbursement under the Act and rules.

[19] TMIC post trial brief at 31-35; TMIC reply brief at 5-6.

[20] The ALJ offers no opinion and makes no decision on whether the methodology used in the Renaissance cases is valid for determining fair and reasonable reimbursement.

D. Conclusion

Vista is not entitled to additional reimbursement from TMIC for the knee surgery services in question. The following table reflects the positions of Vista and TMIC and the MRD, as well as the ALJ's finding that TMIC's reimbursement was fair and reasonable.

	Vista	TMIC	MRD	ALJ
Charges	$14,389.22			
Reimbursement Amount	$6,027.82	$1,221.00	$1,221.00	$1,221.00
Less Payment	($1,221.00)	($1,221.00)	($1,221.00)	($1,221.00)
Balance Due Vista	$4,806.82	$0.00	$0.00	$0.00

III. FINDINGS OF FACT

1. On January 24, 2001, Vista provided ASC services for a knee surgery to a workers' compensation claimant.

2. Vista provided the surgical facility, supplies, and other support functions for the surgical procedure. All ASC procedures are administered on an outpatient basis.

3. TMIC was the responsible workers' compensation insurer for the claimant.

4. Vista requested $14,389.22 reimbursement from TMIC for its ASC services to the claimant.

5. TMIC reimbursed Vista $1,221.00 for the ASC services.

6. At the time Vista provided the services, there was no fee guideline in place for ASC services.

7. TMIC applied its established methodology for fair and reasonable reimbursement to determine the amount it reimbursed Vista.

8. TMIC's methodology and reimbursement amount to Vista ensured access to care; achieved effective medical cost control; did not did not exceed amounts paid on behalf of persons with an equivalent standard of living; considered the security of payment afforded by the workers' compensation system; and were based on assigned values for services involving similar work and resource commitments.

9. Vista requested additional reimbursement for the services in dispute.

10. During 2001, Vista received 16 payments from multiple carriers and other payers for arthroscopic knee surgeries under CPT Code 29870. These payments averaged $6,027.82.

11. The payments to Vista ranged from $716 to $11,613.

12. Vista presented no evidence that the payments it received were based on the applicable criteria for fair and reasonable reimbursement.

13. Vista timely filed a request for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division).

14. On May 29, 2002, the Division issued its Medical Fee Dispute Resolution Findings and Decision and found that no additional reimbursement was owed to Vista.

15. Vista timely requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination.

16. A Notice of Hearing informed the parties of the date, time, and location of the hearing, the matters to be considered, the legal authority under which the hearing would be held, and the statutory provisions applicable to the matters to be considered.

17. A hearing convened before ALJ Thomas H. Walston on March 27, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Christina Hernandez. TMIC was represented by attorney Lauren Damen. The record closed on May 29, 2012, when the parties filed their closing briefs.

IV. CONCLUSIONS OF LAW

1. 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 § 413.031 and Tex. Gov't Code ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Tex. Gov't Code §§ 2001.051 and 2001.052.

3. The services provided to the Claimant were not covered by a fee guideline issued by the Division, and so were required to be billed and reimbursed at a fair and reasonable rate, within the meaning of Tex. Lab. Code § 413.011.

4. Vista had the burden of proof in this proceeding by a preponderance of the evidence.

5. The Division's rules require a carrier to develop an appropriate reimbursement methodology.

6. TMIC's methodology and its reimbursement amount complied with the applicable criteria for fair and reasonable reimbursement.

7. Within the meaning of Tex. Lab. Code § 413.011, $1,221.00 is a fair and reasonable reimbursement for the services at issue provided by Vista.

8. Vista is not entitled to additional payment from TMIC for the services provided to the claimant.

ORDER

IT IS ORDERED that TMIC is not required to pay Vista any additional reimbursement for the services provided to the claimant.

SIGNED July 25, 2012.

THOMAS H. WALSTON
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS