SOAH DOCKET NO. 454-11-5011.M4
DWC NO.

VISTA MEDICAL CENTER HOSPITAL, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
TEXAS MUTUAL INSURANCE CO., **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Vista Medical Center Hospital (Vista) challenges the denial of additional reimbursement by Texas Mutual Insurance Co. (TMIC) for a lumbar epidural steroid injection, fluoroscopy, and related services (ESI) provided to an injured worker on April 14, 2003, at Vista's hospital outpatient facility (HOP) and billed under CPT Code 62311. The Administrative Law Judge (ALJ) finds that a fair and reasonable reimbursement for Vista's services rendered in connection with the ESI is $397.80. 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.

Vista filed a request for medical fee dispute resolution with the Medical Review Division (MRD) of the Texas Department of Insurance, Division of Workers' Compensation (Division).[1] On April 7, 2011, the Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision), denying Vista any additional reimbursement. Vista timely requested a hearing at the State

[1] 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.

Office of Administrative Hearings (SOAH) to contest MRD's determination. A hearing convened before ALJ Gary Elkins on April 10, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Christina Hernandez. TMIC was represented by attorney Thomas Hudson. The record closed on June 15, 2012, following the filing of post-hearing 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.[2] 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.[3] The Act has consistently required that the fee guidelines for medical services be fair and reasonable, ensure quality medical care, and 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

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[2] Tex. Lab. Code § 401.011.

[3] 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.

[4] Tex. Lab. Code § 413.011(d).

individual or by someone acting on that individual's behalf.[5] In setting such guidelines, the increased security of payment afforded by the Act also must be considered.[6]

In 2003, when the ESI was performed, there was no fee guideline applicable to HOP services.[7] 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.[8] 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.[9]

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;
> (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and

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[5] Tex. Lab. Code § 413.011(d).

[6] Tex. Lab. Code § 413.011(d).

[7] Effective March 1, 2008, the Division adopted a fee guideline for outpatient medical services. 28 TAC § 134.403. By its terms, that fee guideline applies only to outpatient medical services provided on or after March 1, 2008.

[8] 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).

[9] 28 TAC § 133.1(8).

(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.[10]

When the Division has not established a fee guideline for a particular procedure, service, or item, the Division's rules require carriers to develop and consistently apply a methodology to determine fair and reasonable reimbursement.[11]

B. Evidence and Analysis

Jacquelyn Pham, Director of Business Financial Services for Doctors Practice Management,[12] testified on behalf of Vista regarding its billings and collections process. She explained that Vista requests recovery based on the average of 155 payments it received from multiple payers for services it provided during 2003 in connection with ESIs provided under CPT Code 62311. The payments ranged from an average of $5,528.62, accounting for all reimbursements by workers' compensation carriers, to $6,147.82, an average derived by removing each payment that is the subject of a fee dispute between Vista and a carrier. Vista asserted that reimbursement falling within the range of $5,528.62 to $6,147.82 represented a fair and reasonable fee. To support this position, Vista cited two recent Division medical fee dispute resolution decisions—involving Renaissance Hospital—as the most current analysis by the Division in cases where the "fair-and-reasonable" standard applies. 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 the same procedures that Renaissance provided was the best evidence in those cases of an amount that would achieve a fair and reasonable reimbursement.[13]

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[10] 28 TAC § 134.1(d)(1)-(3).

[11] 28 TAC § 133.304(i)(1) (eff. July 15, 2000); 28 TAC § 134.1(e) (eff. May 2, 2006).

[12] Doctors Practice Management handles the billing and collection functions for Vista.

[13] MFDR Tracking Nos. M4-08-2454-01 and MR-08-0446-01.

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 1999, even though those Medicare rates had been revised by 2003, when Vista provided its services.

In response, TMIC argued that Vista's methodology was flawed because Vista offered no evidence that the payments it received for ESI services during 2003 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 for CPT Code 62311 varied widely, from $397.80 to $18,060.72, 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. Additionally, TMIC pointed out, the payments far exceeded a fee necessary to ensure quality care, and they far exceeded amounts paid on behalf of other persons with standards of living equivalent to those of workers' compensation patients. TMIC also disagreed with the decisions rendered in the Renaissance Hospital cases. But even if those decisions were accepted, TMIC stressed, the methodology employed in those cases averaged payments for the entire workers' compensation system, whereas Vista averaged only the payments it received at the one facility.

TMIC also asserted that the amount it paid Vista was fair and reasonable reimbursement under the applicable standards. In response to Vista's complaint that TMIC did not increase its payment amount to account for increased Medicare rates in 2001, TMIC presented evidence that Medicare's rate increases were very small. It also argued that, of more importance than the amount of Medicare's increase, there was no indication that a higher payment level was necessary to provide access to quality medical care. As long as adequate access to outpatient services was being achieved, TMIC reasoned, there was no need to increase payment for the services. TMIC also noted that, after the Medicare increase, its $397.80 payment rate for the ESI procedure when performed at a HOP facility remained higher than the Medicare rate of $375.27.

TMIC also offered a substantial amount of evidence—including expert testimony from TMIC Senior Dispute Analyst Richard Ball, an expert report from Research & Planning Consultants, LP, and an expert report from Actuary Mark Mulvaney—that its payments ensured access to care; achieved effective medical cost control; did not exceed amounts paid on behalf of persons with equivalent standards 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 prior cases. Therefore, TMIC argued, both its payment methodology and its payment to Vista were appropriate.[14]

Vista's theory of recovery was not consistent with the Division's decisions in the two Renaissance cases.[15] Furthermore, Vista failed to establish how its proposed reimbursement level of $5,528.62 to $6,147.82 for CPT Code 62311 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 standard reimbursement amount of $397.80 for the ESI procedure did meet the applicable criteria. It also effectively addressed Vista's question about using the 1999 Medicare reimbursement rates to establish its reimbursement rates for 2001 by showing that the increase was negligible and that its reimbursement was above even the revised Medicare rates. Therefore, TMIC established that its payment to Vista for CPT Code 62311 was a fair and reasonable reimbursement under the Act and rules.

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

[15] 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.

C. Conclusion

Vista is not entitled to additional reimbursement from TMIC for the ESI services it provided under CPT Code 62311. TMIC established that its calculated standard reimbursement amount of $397.80 is fair and reasonable.

III. FINDINGS OF FACT

1. On June 26, 2001, Vista Medical Center Hospital (Vista) provided a lumbar epidural steroid injection, fluoroscopy, and related services (ESI) under CPT Code 62311 to a workers' compensation claimant at its hospital outpatient (HOP) facility.

2. Texas Mutual Insurance Company (TMIC) was the responsible workers' compensation insurer for the claimant.

3. Vista billed TMIC $16,280.25 for the ESI.

4. TMIC reimbursed Vista $397.80 for the ESI.

5. Vista requested additional reimbursement for the ESI.

6. TMIC denied additional reimbursement.

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

8. On April 7, 2011, the Medical Review Division (MRD) of the Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision), finding that no additional reimbursement was owed to Vista.

9. Vista timely requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the MRD Decision.

10. 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.

11. A hearing convened before ALJ Gary Elkins on April 10, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Christina Hernandez. TMIC was

represented by attorney Thomas Hudson. The record closed on June 15, 2012, following the filing of closing briefs.

12. At the time Vista provided the services, there was no fee guideline for HOP services.

13. Vista failed to prove that using an average range of payments of $5,528.62 to $6,147.82 for CPT Code 62311 constituted fair and reasonable reimbursement based upon the applicable criteria.

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

15. TMIC's methodology and the amount it paid to Vista for the ESI ensured access to care; achieved effective medical cost control; did not exceed amounts paid on behalf of persons with equivalent standards 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.

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, so they were required to be billed and reimbursed at a fair and reasonable rate, within the meaning of Tex. Lab. Code § 413.011.

4. Vista failed to prove the reimbursement it requested was fair and reasonable.

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

6. Within the meaning of Tex. Lab. Code § 413.011, $397.80 was a fair and reasonable reimbursement for the services at issue.

7. Vista is not entitled to additional reimbursement 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 August 9, 2012.

GARY W. HICKS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS