SOAH DOCKET NO. 454-11-6468.M4
DWC NO

VISTA MEDICAL CENTER HOSPITAL,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
ZURICH AMERICAN INSURANCE	§	
COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Vista Medical Center Hospital (Vista) challenges the denial of additional reimbursement by Zurich American Insurance Company (Zurich) for two hospital outpatient procedures (HOP) performed at Vista's facility. The surgical procedures were provided to an injured worker on October 24, 2003. The first procedure was an arthroscopic examination under anesthesia with debridement of a partial rotator cuff tear and grade I SLAP lesion in the glenohumeral compartment billed under CPT Code 29823. The second procedure was an arthroscopic examination of separate subacromial space with subacromial decompression billed under CPT Code 29826. The Administrative Law Judge (ALJ) finds that Vista failed to prove it was entitled to additional reimbursement. Accordingly, its 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 May 10, 2011, the Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision), denying Vista additional reimbursement. Vista timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest MRD's determination. A hearing convened before ALJ Howard S.

[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.

Seitzman on April 11, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Cristina Y. Hernandez. Zurich was represented by attorney Paul L. Kelley. The record closed on July 25, 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 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]

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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).

[5] Tex. Lab. Code § 413.011(d).

[6] Tex. Lab. Code § 413.011(d).

In 2003, when the two outpatient surgical procedures were 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
> (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]

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[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).

[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).

B. Discussion

In its request for reimbursement presented to Zurich, Vista asked for $38,223.50 for the services it provided to the injured worker. Zurich reimbursed Vista $8,289.00 for those services. Vista requested additional reimbursement of $29,431.49 in its request for medical fee dispute resolution filed at MRD. At MRD, Vista contended that 70% of its billed charges constituted fair and reasonable reimbursement. The MRD Decision found that Vista failed to support its request for additional reimbursement and that no additional reimbursement was owed to Vista.

For the SOAH hearing, Vista requested a lesser recovery based on the average of payments it received from multiple payers for services it provided during 2003 under each of the CPT Codes.[12] Jacquelyn Pham, Director of Business Financial Services for Doctors Practice Management,[13] testified on behalf of Vista regarding its billings and collections process.

For CPT Code 29823, there were only two payments in 2003; a $1,118 payment by a workers' compensation carrier that was in fee dispute resolution, and a $0.00 payment by Medicare. For CPT Code 29826, the payments ranged from an average of $11,620.21,[14] accounting for all reimbursements paid by workers' compensation carriers to Vista, to $21,252.91,[15] an average derived by removing each payment that is the subject of a fee dispute between Vista and a carrier. For CPT Code 29826, Vista asserted that additional reimbursement within a range of $11,620.21 to $21,252.91 represented a fair and reasonable fee.

To support its 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, Vista noted that the Division found

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[12] Vista presented various iterations. The base iteration included all payers. The most refined iteration excluded non-workers' compensation payments, workers' compensation payments still in dispute resolution, and Medicare payments. Medicare payments were excluded because the Division has indicated that the base Medicare payment is not fair and reasonable reimbursement under the Texas regulatory standards for workers' compensation.

[13] Doctors Practice Management handles the billing and collection functions for Vista. Workers' compensation accounted for 76% to 78% of Vista's payor mix in 2003. Tr. at p. 53.

[14] The fifty-five payments ranged in amount from no payment to $44,500.

[15] Based upon seventeen payments ranging from no payment to $44,500.

that the average payment by all insurance carriers in the Texas workers' compensation system during the same year involving the same procedures provided to the injured worker was the best evidence in of an amount that would achieve a fair and reasonable reimbursement.[16]

Also in support of its position, Vista cited Commissioner's Bulletin #B-0009-07 dated May 1, 2007 (Bulletin).[17] The Bulletin provides guidance to hospitals for meeting the criteria in Labor Code § 413.011(d):

> For example, supporting information may be documents showing typical payment amounts received for similar services during the same time period for injured persons of an equivalent standard of living. Those payments could reflect reimbursement from a variety of payors, including managed care, group health, and Medicare. Supporting information may also include documents showing average payments as a percent of total charges from representative Texas workers' compensation carriers during the same time period for a significant number of similar cases. Documentation from only one payor or a limited number of similar cases may not be sufficient to make a determination of the standard for fair and reasonable.

Vista contended that its average-payment methodology complied with the requirements of the Bulletin.

Vista also pointed to Advisory 2003-09 dated July 11, 2003 (Advisory)[18] and a March 2005 Medical Dispute Resolution Newsletter (Newsletter).[19] Both the Advisory and the Newsletter deal with fair and reasonable reimbursement disputes arising from ambulatory surgical center (ASC)

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

[17] Vista Ex. 10. The Bulletin contains the endorsement of Division Commissioner Albert Betts.

[18] Vista Ex. 8. The Advisory bears the endorsement of Richard F. Reynolds, Executive Director of the Division. The Advisory notes that although a Travis County District Court declared the ASC Fee Guideline rule invalid and granted a permanent injunction, the ASC Fee Guideline remains in effect pending exhaustion of all appeals by the Division. The Advisory further states that MRD will review "sample payments in the form of Explanation of Benefits (EOB) or audit summaries" to see if they reflect similar payments for similar treatments for similarly situated injured individuals and reflect "'fair and reasonable' payment not exceeding the typical/ (sic) most dominant payment for all individuals of an equivalent standard of living in Texas." Also, the documentation should provide "sufficient quantity and quality of examples of other payments, when utilized to support these criteria."

[19] Vista Ex. 9. For ASC fee disputes arising from services provided prior to September 1, 2004, the Newsletter indicates that MRD intends to supplement the approach set forth in the Advisory by comparing the disputed amounts with the range of reimbursement recommended in the Ingenix studies "to determine an appropriate reimbursement amount (213.3% to 290% of Medicare for 2004 dates of service with appropriate adjustments for previous years)."

claims not covered by a Division fee guideline. Both provide suggestions similar to those contained in the subsequently issued Bulletin.

Vista's argument that Zurich failed to prove the reimbursement it paid Vista was fair and reasonable included the following assertions:

1. Zurich failed to present any evidence regarding its methodology and how it was developed.

2. Zurich failed to submit nationally recognized public studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the amount paid as a fair and reasonable reimbursement for the services in dispute.

3. Zurich failed to prove its methodology yielded a fair and reasonable reimbursement and complied with the criteria contained in the Act and the Division's rules.

Vista also pointed out that MRD disagrees that the current fee guidelines adopted in 2008 reflect presumptively fair and reasonable reimbursement for dates of service prior to 2008.[20] Therefore, it argued, the average payment analysis made in the recent Renaissance cases is the most current analysis made by the Division in cases where the fair and reasonable standard applies.

Zurich's arguments opposing Vista's request for additional reimbursement included the following:

1. Vista failed to prove it exhausted its administrative remedies.

2. Vista failed to prove the amount reimbursed by Zurich was not fair and reasonable.

3. Vista failed to prove that the reimbursement it seeks is fair and reasonable as defined by statute and Division rules.

4. Unlike the Renaissance cases, Vista's average-payment methodology did not rely on statewide data.

[20] By adopting this position, Vista appears to reject consideration of the approach posited in the Newsletter comparing the disputed amount with the data ranges used in adopting the HOP Fee Guideline.

The ALJ finds that Vista's theory of recovery was not consistent with the Division's decisions in the two Renaissance cases.[21] While Vista provided average-payment data and sample payment data as suggested by the Bulletin, the Advisory, and the Newsletter, it failed to provide any meaningful analysis of that data that would explain or reconcile significant disparities in payments by workers' compensation carriers, or provide some adjustment mechanism for those disparities.[22] Nor did Vista provide evidence showing its average payments were derived "from representative Texas workers' compensation carriers during the same time period for a significant number of similar cases."(Emphasis added.)[23] Vista failed to establish how its proposed reimbursement levels for CPT Codes 29823 and 29826 complied with criteria contained in the Act and the Division's rules for fair and reasonable reimbursement.

However, MRD did not determine that Zurich's payment to Vista was fair and reasonable. And, like Vista, Zurich did not prove its methodology yielded a fair and reasonable reimbursement and complied with the criteria contained in the Act and the Division's rules. Consequently, the evidence in the record is insufficient for the ALJ to determine a fair and reasonable reimbursement for the services rendered by Vista in this case.

C. Conclusion

Vista did not prove it is entitled to additional reimbursement from Zurich for HOP services it provided under CPT Codes 29823 and 29826.

III. FINDINGS OF FACT

1. On October 24, 2003, Vista provided two hospital outpatient procedures under CPT Codes 29823 and 29826 to a workers' compensation claimant at its facility.

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[21] 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.

[22] If one looks at the fifty-five workers' compensation carrier payments, the mean is $11,620.21, but the median is $2,898.50. Twenty-three of the payments are above the mean and thirty-two payments are below the mean. The ten highest payments account for 55% of the total payments, and the five highest payments account for 31% of the total payments.

[23] Whether seventeen payments represent a significant number of similar cases is an unexplored issue.

2. Zurich was the responsible workers' compensation insurer for the claimant.

3. Vista billed Zurich $38,223.50 for the services.

4. Zurich reimbursed Vista $8,289.00 for the services.

5. Vista requested additional reimbursement.

6. Zurich denied additional reimbursement.

7. Vista timely filed a request for medical fee dispute resolution with the Division.

8. The May 10, 2011 MRD Decision found that Vista failed to support its request for additional reimbursement and that no additional reimbursement was owed to Vista.

9. Vista timely requested a hearing before 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 Administrative Law Judge Howard S. Seitzman on April 11, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Cristina Hernandez. Zurich was represented by attorney Paul L. Kelley. The record closed on July 25, 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 a range of payments from an average reimbursement of $11,620.21 to an average reimbursement of $21,252.91 for CPT Code 29826 constituted fair and reasonable reimbursement based upon the applicable criteria.

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 had the burden of proving by a preponderance of the evidence that it was entitled to additional reimbursement.

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

6. Vista is not entitled to additional reimbursement from Zurich for the services provided to the claimant.

ORDER

IT IS ORDERED that Vista is not entitled to additional reimbursement for the services provided to the claimant.

SIGNED September 11, 2012.

HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS