SOAH DOCKET NO. 454-11-6629.M4
DWC NO. _____

VISTA MEDICAL CENTER HOSPITAL, Petitioner	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
AMERICAN HOME ASSURANCE CO., Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Vista Medical Center Hospital (Vista) challenges the denial of additional reimbursement by American Home Assurance Co. (AHAC) for a lumbar caudal epidural steroid injection (ESI) via epidural catheter and fluoroscopy provided to an injured worker on January 2004, at Vista's hospital outpatient facility (HOP) and billed under CPT Code 62311. 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 5, 2011, the Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision), denying Vista additional reimbursement. Vista timely requested a hearing at the State Office of Administrative Hearings (SOAH) to contest MRD's determination. A hearing convened

[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.

before ALJ Gary Elkins on April 10, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Christina Hernandez. AHAC was represented by attorney Nicholas Canaday. The record closed on July 19, 2012, following the filing of post-hearing briefs.

II. DISCUSSION

A. Applicable Law

This case is governed by 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 2004, 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
>
> (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 Arguments

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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).

Jacquelyn Pham, Director of Business Financial Services for Doctors Practice Management,[12] testified on behalf of Vista regarding its billings and collections process. She confirmed that Vista billed $17,166.50 for the ESI and was reimbursed $583.27 by AHAC. She explained that Vista requests recovery based on the average of payments it received from multiple payers for services it provided during 2004 in connection with ESIs provided under CPT Code 62311. The payments ranged from an average of $4,049.66, accounting for all reimbursements by workers' compensation carriers in the 239 admissions for the procedure at Vista during 2004, to $11,785.65, an average derived by removing each payment that is the subject of a fee dispute between Vista and a carrier. Vista seeks the average payment made in cases that were not the subject to a fee dispute. In the alternative, it seeks the average payment made by all workers' compensation carriers for the procedure in 2004, in line with the analysis made in the *Renaissance* cases, and in reliance on Commissioner's Bulletin #B-0009-07, February 2005 Advisory 2003-09, and the MDR Newsletter for March 2005. Based on these authorities, Vista seeks reimbursement within a range of $4,049.66 to $11,785.65, plus interest, which it characterized as fair and reasonable.

Vista points out that AHAC did not offer any testimony in this proceeding. Although AHAC did enter into evidence several authorities as bases for the development and application of its payment methodology, Vista argues, it did not present any evidence that discussed or explained how the amount it paid Vista for the ESI represented a fair and reasonable reimbursement. Vista added that AHAC 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 fairness and reasonableness of its reimbursement amount for the involved services.

Vista also points out that, although the documents submitted by AHAC provide calculations of the current Medicare reimbursement rate for the involved procedure and the application of current guidelines to the services provided in 2004, its reliance on a formula applied to Medicare rates or on current fee guidelines is misplaced. In support of this assertion, Vista referred to a DWC statement

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

in its recent *Renaissance* decision that it disagreed that the current fee guidelines, not in effect until 2008, presumptively represent a fair and reasonable reimbursement under the law for dates of service prior to 2008. Vista also pointed to examples where AHAC's methodology yielded inconsistent results when applied to other cases involving the same procedure.

Ultimately, Vista points out, the average payment it received in 2004 from the various workers' compensation carriers for the ESI procedure—including cases involving fee disputes between Vista and a carrier—was $4,049.66, but AHAC's payment methodology yielded a payment amount—$583.27—that was far less than the average payment received by Vista.

In support of its position that Vista did not meet its burden of proof in this case, AHAC makes a number of arguments, including the following:

- The average-payment approach used by Vista does not establish a fair and reasonable fee;
- Vista's request for reimbursement is not fair and reasonable when considered in the context of the criteria found in Tex. Lab. Code § 413.011, as clarified by 28 Tex. Admin. Code § 134.1;
- health care providers cannot set their own fees;
- the *Renaissance* decisions are inapposite and inapplicable to this case because significant factual distinctions exist between them;
- Vista's methodology has been rejected by both the DWC and in SOAH decisions; and
- Vista's fee exceeds known fair and reasonable fees and other benchmark fees.

AHAC also points out that its $583.27 reimbursement equaled the Medicare rate of $398.00 for the ESI times a multiplier of 1.46, constituting a fair and reasonable reimbursement.

C. Analysis and Conclusion

Vista's theory of recovery was not consistent with the Division's decisions in the *Renaissance* cases.[13] Furthermore, Vista failed to establish how its requested reimbursement range of $4,049.66 to $11,785.65 for services provided under CPT Code 62311 complied with criteria contained in the Act and rules for fair and reasonable reimbursement. Because Vista did not meet its burden of proof, is not entitled to additional reimbursement.

III. FINDINGS OF FACT

1. On January 2004, Vista Medical Center Hospital (Vista) provided a lumbar caudal epidural steroid injection (ESI) via an epidural catheter and fluoroscopy, under CPT Code 62311, to a workers' compensation claimant at its hospital outpatient (HOP) facility.

2. American Home Assurance Co. (AHAC) was the responsible workers' compensation insurer for the claimant.

3. Vista billed AHAC $17,166.50 for the ESI.

4. AHAC reimbursed Vista $583.27 for the ESI.

5. Vista requested additional reimbursement for the ESI.

6. AHAC 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 May 5, 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. AHAC was represented by attorney Nicholas Canaday. The record closed on July 19, 2012, following the filing of closing briefs.

[13] 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.

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 $4,049.66 to $11,785.65 for CPT Code 62311 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 workers' compensation 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. Vista is not entitled to additional reimbursement from AHAC.

ORDER

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

SIGNED September 14, 2012.

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