SOAH DOCKET NO. 454-11-8028.M4
DWC NO. M4-05-A576-01

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 via epidural catheter (ESI), provided to an injured worker on April 16, 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 April 7, 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

[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.

State 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 Y. Hernandez. AHAC was represented by attorney Steven M. Tipton. The record closed on June 18, 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]

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

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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).

[7] Effective March 1, 2008, the Division adopted a fee guideline for outpatient medical services. 28 TAC §

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

1. Vista

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 explained that Vista requests recovery based on the average payment it received for services it provided during 2004 under CPT Code 62311. The payments ranged from an average of $4,254.05, accounting for all reimbursements paid by workers' compensation carriers to Vista, to $4,476.32, 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 $4,254.05 to 4,476.32 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, Vista pointed out, 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]

Vista added that AHAC's payment for the ESI—at $1,118—was less than the average paid by other carriers. It also argued that a recent MRD decision held that the respondent carrier in a workers' compensation dispute also bears a burden to submit documentation that discusses, demonstrates, and justifies that the amount being reimbursed by the carrier is fair and reasonable. Despite this requirement, Vista pointed out, AHAC failed to present any testimony regarding its methodology, how it was developed, or what formula it was based on. Vista also argued 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 amount paid as a fair and reasonable reimbursement for the services in dispute.

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. Therefore, Vista reasoned, any arguments by AHAC regarding reimbursement based on a Medicare-based methodology or current fee guidelines would not apply. Instead, it argued, the average

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[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.

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.

2. AHAC

AHAC's arguments in response to Vista's theory of recovery include following:

- Vista's reliance on a completely new ground for establishing fair and reasonable reimbursement, after initially asserting that it was entitled to either its full, billed charges as fair and reasonable or 70 percent of its billed charges, is not permitted based on longstanding case law, statutes, rules, and policies adopted by the Division, and SOAH does not have jurisdiction to consider the new claim.

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

- Historical payments in an unregulated market are not evidence that payments Vista received are consistent with the regulated market anticipated by the statute and the Division's rules.

- Vista provided no statistical validation for the use of its own historical payment database or the treatment of that data using a simple arithmetic mean.

In response to Vista's assertion that AHAC was required to explain its methodology of reimbursement following a provider's request for dispute resolution, AHAC makes the following arguments:

- Vista cited no authority for this position.

- The burden of proof has always been on the provider to prove entitlement to additional reimbursement.

- There are no policies, rules, or decisions from the Division that invoke death penalty sanctions for any perceived failure of a carrier to explain its method of reimbursement.

- Although the carrier is required to provide some evidence to the provider regarding its reimbursement methodology so that the provider can decide whether to dispute the payment, the information is not critical to the adjudication of disputes.

In response to Vista's reliance on the Renaissance cases for its theory of recovery, AHAC pointed out that those decisions relied solely upon average payment calculations to order additional

reimbursement without explaining how each payment used was fair, reasonable, and in compliance with statutory requirements. AHAC also noted that the raw data used in the Renaissance cases was based on ICD-9 procedure codes. Thus, guess work was required in order to determine the specific medical service provided and, therefore, the CPT Code applicable to each bill. The only rationale to be gleaned from the Renaissance decisions, AHAC argues, appears to be that the medical dispute resolution officer who issued the decision believed that, because the State had collected the payment data, the data must have value for the purposes for which it was being offered. AHAC added that the fact that workers' compensation carriers reported payment data from their EOBs does not alter the uselessness of the data for the purposes of determining a fair and reasonable reimbursement.

AHAC also pointed out that the only negotiated fee in evidence in this case was a contract Vista had with Aetna in which it agreed to accept payments of $466 for the ESI procedure, which amounted to approximately 140 percent of Medicare. AHAC emphasized that its $1118 reimbursement for the procedure far exceeded the Vista-Aetna contract, the $331.10 Medicare Ambulatory Surgery Center (ASC) amount, and even the $1,062 reimbursement rate from the Vista-Aetna contract for a one-day inpatient surgical admission. It added that its reimbursement also exceeded the amount that would have been due using the payment adjustment factors adopted by the Division: 213.3% in the 2004 ASC guideline and 200% in the 2008 outpatient guideline.

C. Analysis and Conclusion

Vista's theory of recovery was not consistent with the Division's decisions in the two Renaissance cases.[14] Furthermore, Vista failed to establish how its proposed reimbursement level of $4,254.05 to 4,476.32 for CPT Code 62311 complied with criteria contained in the Act and the Division's rules for fair and reasonable reimbursement. Because Vista did not meet its burden of proof, it is not entitled to additional reimbursement from AHAC for the ESI services it provided under CPT Code 62311.

III. FINDINGS OF FACT

1. On April 16, 2001, Vista Medical Center Hospital (Vista) provided a lumbar caudal epidural

[14] 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.

steroid injection via epidural catheter (ESI) 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 $16,572.60 for the ESI.

4. AHAC reimbursed Vista $1118.00 for the ESI.

5. Vista requested additional reimbursement.

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 31, 2011, the Division's Medical Review Division (MRD) 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 before 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 Administrative Law Judge 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 Steven M. Tipton. The record closed on June 18, 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 $4,254.05 to 4,476.32 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 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 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 August 16, 2012.

GARY W. [illegible]KINS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS