SOAH DOCKET NO. 454-11-9584.M4
DWC NO. ____

VISTA MEDICAL CENTER HOSPITAL, Petitioner	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
_____, Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Vista Medical Center Hospital (Vista) challenges the denial of additional reimbursement by _____ for hospital outpatient (HOP) services, specifically a manipulation under anesthesia of a shoulder joint (MASJ), CPT Code 23700, provided to an injured worker on December 14, 2006. The Administrative Law Judge (ALJ) finds that the evidence failed to prove Vista is entitled to additional reimbursement for services rendered in connection with the MASJ procedure. Accordingly, Vista's request for additional reimbursement is denied.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

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 July 28, 2011, the Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision), denying Vista any additional reimbursement. Vista requested a hearing at the State Office of Administrative Hearings (SOAH) to contest MRD's determination. A hearing convened before ALJ Stephen J. Pacey on May 8, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Cristina Hernandez. ____ was represented by attorney J. Red Tripp. The record closed on September 19, 2012, when the parties filed their closing briefs.

[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."

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]

Prior to March 1, 2008, the Division did not have a fee guideline for medical services provided in an outpatient acute care hospital.[7] In reimbursing providers for services without a fee guideline, an insurance carrier is required to reimburse at a fair and reasonable rate, as

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[2] Labor 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. Labor Code § 413.011(d).

[5] Tex. Labor Code § 413.011(d).

[6] Tex. Labor 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.

described in Section 413.011(d) of the Act.[8] Until May 2006, "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. Discussion

In its request for reimbursement presented to ___, Vista requested $14,048.50 for the services it provided to the injured worker. ____ reimbursed Vista $1,453.40 for those services. Vista sought additional reimbursement of $6,426.45 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 did not establish the amount it requested was fair and reasonable.

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[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). In 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). Amended in 2008 to 28 TAC § 134.1(f)(1)-(3).

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

For the SOAH hearing, Vista altered its theory and requested recovery based on the average for CPT Code 23700 in cases that were not subject to a fee dispute. Vista asserts that including the payments that are subject to a fee dispute would be unfair and skewed since it is disputing those payments. In the alternative, Vista seeks the average payment made by all workers' compensation carriers for the services billed in line with the analysis in the Renaissance cases and in reliance on Commissioner's Bulletin #B-0009-07[12] and a March 2005 MDR Newsletter.[13] Vista seeks additional reimbursement within a range of the two averages, plus interest. In addition to the $1,453.40, Vista seeks reimbursement of approximately $3,773.47. Vista asserted that this amount for CPT Code 23700 is a fair and reasonable reimbursement.

To support its position, Vista relied on two recent Division 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 the same procedures that Renaissance provided was the best evidence in those cases of an amount that would achieve a fair and reasonable reimbursement.

Vista also argued that ___ did not present evidence that its methodology produces a fair and reasonable reimbursement under the statutory standards. Although ___ offered evidence showing the amount it reimbursed Vista, Vista asserted that ___ did not present sufficient evidence that the amount it reimbursed Vista was fair and reasonable under the statutory standards.

____ argued that Vista's theory of recovery asserted at the SOAH hearing was flawed because Vista offered no evidence that the payments it received for the MASJ during 2006 were based on the criteria for fair and reasonable reimbursement established in the Act and the Division's rules. ____ further asserted that there is a significant difference between Vista's average payments and those approved by the MRD in the Renaissance cases. ____ pointed out that Vista's use of its limited, unsubstantiated historical payment data not only failed to establish a fair and reasonable rate, it also failed to demonstrate cost control. ____ contended that Vista

[12] Vista Ex. 10.
[13] Vista Ex. 9.

provided no evidence on how it calculates its usual and customary billing numbers. Furthermore, ___ argued that Vista used its own historical payment database for Vista's reimbursement and that data is lacking and therefore inherently biased.

____ presented evidence of its fair and reasonable reimbursement methodology through Jennifer Dawson. Ms. Dawson is the Medical Benefits and Disability Management Manager, who assisted in the development of ____ outpatient surgical reimbursement methodology. Ms. Dawson testified that ___ outpatient surgical methodology was a consistently applied per diem methodology and was based "on an internal methodology that ____ created using the preamble, the acute care inpatient fee guideline, and ____ added some additional allowances for overhead." This methodology was used by ____ from 2003 through 2008. ____ methodology was based on TWCC's accumulation of 12,000 medical bills and 2,500 managed care contracts, including Medicare, state, and federal hospital care information.

___ adopted the $1,118.00 per diem payment allowed by the Acute Care Hospital Inpatient Fee Guides, with an added 30% for any unforeseen costs, and allowed for carve-outs. This comes to a reimbursement payment of $1,453.40 as a per diem payment for outpatient surgical services. Ms. Dawson said that ___ based its reimbursement methodology on the Division's extensive research and values assigned for services involving similar work and resource commitments.

Ms. Dawson testified that $1,453.40 for outpatient surgical services assured access to medical care. This reimbursement would also assure quality of care for outpatient surgical services because, if the reimbursement rate was sufficient for the 24 hours of inpatient care, it would be adequate for outpatient surgical services as well. Ms. Dawson explained this would achieve effective cost controls: the Division's extensive research of managed care contracts (a fair market value as the negotiated rates between a facility and an insurance carrier) determined that the $1118 per diem rate would ensure effective cost controls.

Ms. Dawson testified that ___ also took into consideration whether the reimbursement would exceed the fee charged for similar treatments by a person of a similar standard of living,

and it based its determination on the Division research. She said that ____ consistently applied its methodology to all outpatient surgical services from 2003-2008, which ensured that similar procedures provided in similar circumstances received similar reimbursement.

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 additional reimbursement level of $3,773.47 for CPT Code 23700 complied with criteria contained in the Act and rules for fair and reasonable reimbursement. Accordingly, Vista did not meet its burden of proof; consequently, it unnecessary to rule on the merits of ___ methodology.

C. Conclusion

Vista did not establish that the amount it seeks is fair and reasonable. Consequently, it is not entitled to additional reimbursement from some ____ for the MASJ in question.

III. FINDINGS OF FACT

1. On December 14, 2006, Vista provided hospital outpatient (HOP) services for administration of a manipulation under anesthesia of a shoulder joint (MASJ) to a workers' compensation claimant.

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

3. Vista billed $14,048.50 for the MASJ.

4. ____ reimbursed Vista $1,453.40 for the MASJ.

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

6. At the Medical Review Division (MRD) Vista requested $6,426.45 additional reimbursement for the services in dispute.

7. ___ denied Vista's request for additional reimbursement.

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

9. On July 28, 2011, MRD issued its Medical Fee Dispute Resolution Findings and Decision and found that no additional reimbursement was owed to Vista.

10. Vista timely requested a hearing at ___ to contest the MRD Decision.

[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.

11. 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.

12. A hearing convened before ALJ Stephen J. Pacey on May 8, 2012, at SOAH's facilities in Austin, Texas. Vista was represented by attorney Cristina Hernandez. ___ was represented by attorney J. Red Tripp. The record closed on September 19, 2012, when the parties filed their closing briefs.

13. Vista seeks the average payment made by all workers' compensation carriers for the services billed in line with the analysis in the Renaissance cases and in reliance on Commissioner's Bulletin #B-0009-07 and a March 2005 MDR Newsletter.

14. Vista seeks additional reimbursement of $3,773.47.

15. Vista failed to prove that an additional $3,773.47 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, and so were required to be billed and reimbursed at a fair and reasonable rate, within the meaning of Tex. Labor Code § 413.011.

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

5. Vista did not prove the additional reimbursement it sought complied with the applicable criteria for fair and reasonable reimbursement.

6. Vista failed to prove it is entitled to additional payment from ____ for the services provided to the claimant.

ORDER

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

SIGNED November 12, 2012.

STEPHEN J. PACEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS