SOAH DOCKET NO. 454-12-1987.M4
DWC NO. ___

SOAH DOCKET NO. 454-12-2002.M4
DWC NO. ___

SOAH DOCKET NO. 454-12-2005.M4
DWC NO. ____

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

DECISION AND ORDER

Vista Medical Center Hospital (Vista) challenges the denial of additional reimbursement by _____ for hospital outpatient procedures (HOP) performed at Vista's facility on four separate occasions for the same injured worker. The services were provided on October 3, 2006,[1] October 31, 2006,[2] December 5, 2006,[3] and March 20, 2007.[4] The October 3, 2006 and the October 31, 2006 services included an aspiration and injection to a major joint in the hip billed under CPT Code 20610. The December 5, 2006 service included a sacroiliac joint block to the lumbar spine cervical epidural steroid injection billed under CPT Code 64622. The March 20, 2007 service included the implantation of a spinal neurostimulator in the cervical spine billed under CPT Code 63650. The Administrative Law Judge (ALJ) finds that Vista failed to prove it was entitled to additional reimbursement in SOAH Docket Nos. 454-12-1987.M4, 454-12-2002.M4, and 454-12-2005.M4. Accordingly, Vista's request for additional reimbursement is denied.

[1] SOAH Docket No. 454-12-1987.M4.

[2] SOAH Docket No. 454-12-1987.M4.

[3] SOAH Docket No. 454-12-2002.M4.

[4] SOAH Docket No. 454-12-2005.M4.

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. For each date of service, 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).[5] On July 27, 2011, the Division issued a Medical Fee Dispute Resolution Findings and Decision (MRD Decision) denying Vista additional reimbursement for the March 20, 2007 service. On July 28, 2011, the Division issued a Medical Fee Dispute Resolution Findings and Decision (MRD Decision) denying Vista additional reimbursement for the October 3, 2006, October 31, 2006, and December 5, 2006 services. Vista timely requested hearings before the State Office of Administrative Hearings (SOAH) to contest the MRD Decisions. 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 Y. Hernandez. ___ was represented by attorney J. Red Tripp. After post-hearing briefing, the records closed on September 19, 2012.

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.[6] 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

[5] 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."

[6] Tex. Lab. Code § 401.011.

treatments or services.[7] 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.[8] 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.[9] In setting such guidelines, the increased security of payment afforded by the Act also must be considered.[10]

Prior to March 2008, the Division did not have a fee guideline for HOP services.[11] 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.[12] 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.[13]

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[7] 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.

[8] Tex. Lab. Code § 413.011(d).

[9] Tex. Lab. Code § 413.011(d).

[10] Tex. Lab. Code § 413.011(d).

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

[12] 28 TAC § 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).

[13] 28 TAC § 133.1(8).

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.[14]

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.[15]

B. Discussion

In its request for reimbursement presented to ___ for both the October 3, 2006 and October 31, 2006 services, Vista requested $28,653.58, and ___ reimbursed Vista $2,906.40. In its request for reimbursement presented to ___ for the December 5, 2006 service, Vista requested $21,731.00, and ___ reimbursed Vista $1,453.40. In its request for reimbursement presented to ___ for the March 20, 2001 service, Vista requested $37,548.27, and ____ reimbursed Vista $1,453.40. 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 2006 and 2007 under each of the CPT Codes.[16] Jacquelyn Pham, Director of Business Financial Services for Doctors Practice Management,[17] testified on behalf of Vista regarding its billings and collections process. For CPT

[14] 28 TAC § 134.1(d)(1)-(3). Amended in 2008 to 28 TAC § 134.1(f)(1)-(3).

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

[16] 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.

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

Code 20610, the payment based on the average was $5,185.764 for the services. For CPT Code 64622, the payment based on the average was $4,650.38 for the services, and for CPT Code 63650, the payment based on the average was $9,016.27 for the services. Vista requested these amounts as additional reimbursement and represented that they were fair and reasonable.

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. Vista noted that in those cases the Division found 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.[18]

Also in support of its position, Vista cited Commissioner's Bulletin #B-0009-07 dated May 1, 2007 (Bulletin).[19] 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 payer 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),[20] and a March 2005 Medical Dispute Resolution Newsletter (Newsletter).[21] Both the Advisory and the Newsletter deal

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[18] MFDR Tracking Nos. ___ and ____.

[19] Vista Ex. 9 The Bulletin contains the endorsement of Division Commissioner Albert Betts.

[20] Vista Ex. 7. 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

with fair and reasonable reimbursement disputes arising from ambulatory surgical center (ASC) claims not covered by a Division fee guideline. Both the Advisory and the Newsletter provide suggestions similar to those contained in the subsequently issued Bulletin.

Vista's arguments that ___ failed to prove the reimbursement it paid Vista was fair and reasonable included the following:

1. ___ failed to present any evidence or testimony of how its methodology yields a fair and reasonable reimbursement.

2. ___ 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. ____ 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.[22] 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.

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

1. 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

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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."

[21] Vista Ex. 8. 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)."

[22] 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.

based on longstanding case law, statutes, rules, and policies adopted by the Division, and SOAH does not have jurisdiction to consider the new claim.

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

3. 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.

4. Vista failed to base its averages on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments.

5. The Renaissance cases are not analogous to Vista's averages because the Renaissance cases were based on state-wide annual, average reimbursement paid by all insurance carriers in the Texas workers' compensation system for the same principal diagnosis code and principle procedure code of the disputed services during the same year that the services were rendered. and the Renaissance theory of recovery is flawed.

____ also argued that Vista admits excluding all payments made under Medicare yet contends that this is the fair average. ____ asserted that permitting Vista to pick and choose which categories of bills it includes in the number sets to be averaged is tantamount to allowing a provider to choose the level of reimbursement. According to ___, the Division has determined that the hospitals ought not to be allowed to inflate their reimbursement by manipulating the numbers.

In response to Vista's assertion that ___ was required to explain its methodology of reimbursement following a provider's request for dispute resolution, ___ argued that it is under no obligation to offer any evidence that its reimbursement amount was fair and reasonable. However, ____ did present evidence alleging that its reimbursement amount is a fair and reasonable reimbursement amount under Texas Labor Code §413.011 and Rule 134.1.

___ 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 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. SORM's 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 $1118.00 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 $1453.40 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 $1453.40 for outpatient surgical services assured access to medical care. This reimbursement would also assure quality of care for outpatient surgical stays 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 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 receive similar reimbursement.

The ALJ finds that Vista's theory of recovery was not consistent with the Division's decisions in the two Renaissance cases.[23] 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. Nor did Vista provide evidence showing its average payments were derived "from representative Texas

[23] 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.

workers' compensation carriers during the same time period for a significant number of similar cases." Vista failed to establish how its proposed reimbursement level for CPT Codes 20610, 64622, and 63650 complied with criteria contained in the Act and the Division's rules for fair and reasonable reimbursement. Vista did not meet its burden of proof; consequently, it unnecessary to rule on the merits of SORM's methodology.

C. Conclusion

Vista failed to establish that it is owed additional reimbursement for the services it rendered in SOAH Docket Nos. 454-12-1987.M4, 454-12-2002.M4, and 454-12-2005.M4.

III. FINDINGS OF FACT

1. Hospital outpatient procedures (HOP) were performed at Vista Medical Center Hospital's (Vista) facility on four separate occasions for the same injured worker. The services provided on October 3, 2006, and October 31, 2006, included an aspiration and injection to a major joint in the hip billed under CPT Code 20610; the December 5, 2006 service included a sacroiliac joint block to the lumbar spine cervical epidural steroid injection billed under CPT Code 64622; and the March 20, 2007 service included the implantation of a spinal neurostimulator in the cervical spine billed under CPT Code 63650.

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

3. In its request for reimbursement presented to __ for the October 3, 2006 and October 31, 2006 services, Vista requested $28,653.58, and ___ reimbursed Vista $2,906.40 for those services. Vista requested additional reimbursement, which ___ denied.

4. In its request for reimbursement presented to ___for the December 5, 2007 service, Vista asked for $21,731.00, and ___ reimbursed Vista $1453.40 for those services. Vista requested additional reimbursement, which __ denied

5. In its request for reimbursement presented to __ for the March 20, 2007 service, Vista requested $37,548.27, and ___ reimbursed Vista $1453.40 for those services. Vista requested additional reimbursement, which ___ denied.

6. Vista timely filed a request for medical fee dispute resolution with the Division for each of the services.

7. On July 27, 2011, the Division issued its Medical Fee Dispute Resolution Findings and Decisions (MRD Decision), denying Vista additional reimbursement for the March 2007 service. On July 28, 2011, the Division issued its MRD Decision denying Vista additional reimbursement for the October 2007, and December 5, 2006 services.

8. Vista timely requested hearings before the ____ to contest the MRD determinations.

9. 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.

10. 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 Y. Hernandez. ____ was represented by attorney J. Red Tripp. The records closed on September 19, 2012, following the filing of post-hearing briefs.

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

12. Vista failed to prove that an additional payment of $4,650.38 for the two services for CPT Code 20610 constituted fair and reasonable reimbursement based upon the applicable criteria.

13. Vista failed to prove that an additional payment of $5,185.76 for the service for CPT 64622 would constitute fair and reasonable reimbursement based upon the applicable criteria.

14. Vista failed to prove that an additional payment of $9,016.27 for the service for CPT Code 63650 would constitute fair and reasonable reimbursement based upon the applicable criteria.

15. Vista did not prove ___ owes additional reimbursement on the four dates for service under CPT Codes 20610, 64622, and 63650.

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 establish that it is entitled to additional reimbursement for the services it rendered in SOAH Docket Nos. 454-12-1987.M4, 454-12-2002.M4, and 454-12-2005.M4.

ORDER

IT IS ORDERED that Vista is not entitled to additional reimbursement for the services it provided to the claimant in SOAH Docket No. 454-12-1987.M4 on October 3, 2006 and October 31, 2006; in SOAH Docket No. 454-12-2002.M4 on December 5, 2006; and in SOAH Docket No. 454-12-2005.M4 on March 20, 2007.

SIGNED November 12, 2012.

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