ORAL ARGUMENT – 9/11/03
02-0804
TEXAS WORKERS COMP. V. PATIENT ADVOCATES OF TEXAS

HELMCAMP: Petitioner and crossrespondent Texas Workers' Comp. Comm. (TWCC) respectfully asks that at the conclusion of this proceeding the court do two things with regard to this case. The first thing is affirm that portion of the CA's opinion, which upheld the validity of the 1995 medical fee guideline, and one of the dispute and audit rules, the so called one year statute of limitations. Second, we ask that the court reverse and render that portion of the CA's opinion which held that the remainder of the so-called dispute and audit rules constituted an improper delegation of governmental power to a private entity without sufficient standards in violation of the Boll Weevil standards and this court's previous decision.

The commission would begin by respectfully reminding the court or informing the court the worker's comp. system is a complicated but carefully crafted scheme established by the legislature to provide for the care for injured workers of compensable injuries. There are three components, or three protagonist in the system. The first is the injured worker; the second is the medical provider or health care provider who treats the injury; the third is the insurance carrier or other third party payor who pays the bill.

This case arises out of a challenge as you know to several of the commission's rules.

If you look at the worker's comp. statute, which is a carefully crafted statute, you will see first off the commission has broad authority to adopt those rules necessary for the implementation and the enforcement of the Act. This is found in §402.061 of the Texas Labor Code, which is in fact the Worker's Comp. Act.

One of the key things that the CA missed in arriving at its decision that there was an improper Boll Weevil delegation, and it never discussed the specific statutory provision in §408.027. This provision of the Labor Code is very important because it is the statutory recognition that insurance carriers and other third party payors shall pay an appropriate bill unless they choose to audit that bill to determine whether the amount of payment is appropriate or the authorization for payment is appropriate.

And what that means is just two things. Insurance carriers and other third party payors have an obligation and a recognition by the legislature that they must in fact review and audit bills provided by health care providers to determine, is the fee that is being charged proper? has the health care provider for example improperly unbundled specific procedures? have they charged an amount in excess of the maximum, allowable reimbursement set by commission rule, such as the medical fee guideline? Any number of other things that might be involved with a fee

dispute.

The second part of that statutory recognition of carrier authority is the carrier's responsibility to ensure that the medical care which has been provided is in fact reasonably necessary for the injured worker.

We do not disagree with patient advocates that an injured worker is entitled to all medical care reasonably necessary for a compensable injury. But the issue here or one of the subissues is simply whether or not medical care in a specific instance is in fact required.

SCHNEIDER: Why would the legislature be allowed to have an insurance company come and go through all my records and basically conduct a search and seizure almost, at least a search?

HELMCAMP: I must respectfully disagree with the characterization. Certainly that's how PAT would characterize what happen. The legislature recognizes that the Texas WCC performs the oversight or referee rule in this process. The commission simply is not staffed nor funded to be that sort of a referee.

SCHNEIDER: Let's say we didn't staff the DPS. Would that be a good reason to allow the Salvation Army to go conduct searches or stop speeders?

HELMCAMP: No. I don't think so. I think the difference is that the worker's comp. system is nothing more or less than a creature of statute. It is created by the legislature to provide the framework and the scheme of statutory provisions augmented by commission rules to govern the provision of health care and the payment for that health care. And it's a totally different situation than the DPS situation.

O'NEILL: The problem with the rules as I see they're claiming them is that it puts too much discretion in the carrier's hands in two manners. One, it allows them to set fees for services where there's not an MAR. They can set fees and apparently they are very different fees depending upon the fee structure of the individual carrier, which is not subject to review as best I can tell. And two, it allows the carrier to determine timing and ultimately to delay and delay and delay, and so it puts a lot of discretion and power into the carrier's hands, and by delegating that discretionary power there's been an illegal delegation here.

HELMCAMP: We need to point out that there are many other controls and safeguards in the system. It is certainly true that any insurance carrier or other third party payor has to exercise the discretion over which bill to review and/or audit. The court should understand that in the system annually there are more than 10's of millions...

O'NEILL: I'm not talking about so much which bill to audit. It's the ability to draw out the audit. Is there any methodology whereby a provider can expedite the audit, or get it up for review sooner?

HELMCAMP: Absolutely. If you look at the actual rules themselves, I must confess they are quite complicated and that's of necessity because of the need to regulate which is what this system does. But to answer your question, the rules require that the carrier must notify the health care provider if it intends to do any on site audit, and it only has 14 days, specific time limits involved. But all the power is not in the insurance carrier.

O'NEILL: The crux of their argument I think is that the review procedure is so timely that by dragging it out to the maximum of the review procedures and delay payment for so long it forces the provider to just give up early and say okay.

HELMCAMP: What Patients Advocates doesn't tell you is the regulations require that if a carrier audits a bill after the 60th day from the complete medical bill was submitted, the carrier must pay interest to the health care provider on that bill. So there is in fact a positive incentive for the carrier or other payor to promptly complete the audit and to promptly pay or if they deny payment based upon the audit allow the provider to go forward. And the interest will in fact accrue.

The second thing that's a control mechanism that I think answers your question is that the commission has a compliance and practices division. Anytime a health care provider feels that any insurance carrier is unduly harassing them or is unduly delaying an audit in an attempt to slow pay, they may file a complaint with the compliance and practices division who will in fact under the commission's own separate independent audit authority review that situation and if it's appropriate assess administrative penalties on that carrier.

JEFFERSON: What does the record reflect about the commission's oversight, and in particular are there instances that the record shows in which the commission has come down has penalized for a delay of the carrier in auditing or evaluating the claim? Has it found actually improper auditing or accounting procedures?

HELMCAMP: I'm not sure the record itself from the courts below reflects that specific thing. But I believe in the amicus brief filed by Texas Mutual they specifically cite some of the figures by the worker's comp. comm. I can tell you that generally for the last 3-4 years, the commission has assessed administrative penalties collectively against insurance carriers over $1 million/year. This is for all sorts of violations of the provisions of the act that occur. So the commission expressly exercises that tight control to prevent a runaway carrier from just slow paying or avoiding their responsibilities.

By contrast and to show the distinction only about $50,000 roughly year in and year out has been assessed against health care providers for administrative violations of the act.

I believe that's the closest evidence or mention of any form because we simply didn't address that. It wasn't a part of the specific case at the TC nor in the CA.

JEFFERSON: The federal courts when they talk about this, what they determine is

subdelegation, one of the primary factors that they look as is whether there's a conflict of interest. And I note that the CA at least says that all parties agree that there's a conflict of interest here. Why doesn't that amount to an improper subdelegation?

HELMCAMP: As the court held in both the Boll Weevil case and in the FM Properties case, there are 8 factors to be looked at, not one of which is controlling. And we certainly don't dispute the fact that there may very well be certainly some degree of tension between a health care provider who wants to get paid as much as possible, and an insurance carrier who has a statutory responsibility to pay not more than the medical fee guideline allows.

But that's only one factor. If the court were to take a look at this from the Boll Weevil delegation standards and really look all 8 of the factors, which the 3rd court did not do, you will in fact ascertain that a careful examination and application of the Boll Weevil factors even if this is a delegation, which we say it is not, those factors are all satisfied by the governmental control and all of the other key things.

WAINWRIGHT: You've been calling the procedures an audit, so that may suggest the answer to my question. The WCC argues, at least in part, that the review procedures or audit are to enable the carrier to ensure that the amount of the payment to the health care provider is the correct amount are reasonable and fair amount. Not too high. Perhaps not too low. On the other hand it's been argued that it's a delegation of complete audit responsibility that the commission has. Which is it, and does it make a difference to the outcome in this case?

HELMCAMP: It is not a delegation of the commission's power at all. And that's why I mentioned specifically §408.027. Carriers have a legislatively recognized responsibility to look at medical bills. The commission's audit authority is totally separate and distinct. I would refer the court to §413 and §414 of the Texas Labor Code, because it is in those two specific sections where you will find all of the commission's authority to audit healthcare providers, insurance carriers, and anyone else in the system.

WAINWRIGHT: Aren't those the same statutes however that the commission uses to justify the insurer's ability to conduct these reviews?

HELMCAMP: They are both. They are part of the Texas Labor Code, that carefully crafted scheme by which the commission oversees the process.

WAINWRIGHT: So the commission's review authority comes from the same statutes as the carriers, at least alleged delegated review authority. But you're argument is they are distinct.

HELMCAMP: Right. They are separate and distinct. And that's they key point that the CA missed on the delegation issue.

O'NEILL: We're calling this a review and an audit, which implies some sort of review

type procedure. But the arguments made that it's more than just a review. It's a fee setting. And that that is strictly within the auspices of the commission and it's fee setting because each carrier has a different structure in terms of what they are going to pay. That seems to me to be the crux of their argument in the delegation piece.

HELMCAMP: And you sort of had that in your first question and we got away from it. The provision that is complained of is found in Rule 133.304(I). This is the specific commission rule which sets up the non MAR situation. That rule and if you look at the preamble to it, which is mentioned in their brief...

O'NEILL: Also the MAR situation, it's my understanding that just sets the maximum. It doesn't set the actual rate. So I believe their fee setting argument includes those that have MARS, because the carrier can pay anything within a certain range.

HELMCAMP: No. That's totally incorrect. If you look at the rules and the statute itself insurance carriers and other payors have only two choices: assume it's a proper medical bill and it's for a compensable service, they carrier either has to pay the maximum allowable reimbursement set by commission rule where for any of the 8,000 procedures it had set a MAR, or it pays the carrier's charge whichever is less. The carrier has absolutely no discretion in the MAR situation to pay anything that it sees fit.

In 133.304(I), which is the Non-MAR rule, the commission has given insurance carriers specific direction and authorization to determine a methodology for paying certain narrow instances of medical treatment for which the commission has not established that maximum allowable. However, the commission has specifically also told those carriers that when you do that you must apply the statutory standard found in §413.011(d). That's the fair and reasonable standard that we've talked so much about. So the short answer is, carriers absolutely do not have discretion...

O'NEILL: I think I heard you just say that each carrier can setup their own methodology under nothing more than just fair and reasonable.

HELMCAMP: There's a little more than fair and reasonable. Because when you look at the statutory standards, what you will realize is that it's fair and reasonable, it must ensure access to quality medical care, and it must achieve effective cost control. Furthermore, the carrier has to take into consideration the extra security of payment; and finally they cannot pay more than that which would be allowed by a person paying for their own medical care, or if an insurance carrier was paying for it.

O'NEILL: Other than those broad guidelines it's pretty much up to the carrier what to charge in that situation.

HELMCAMP: It is subject to commission review. Because if a healthcare provider feels that that methodology has not paid them fair and reasonable they may ask for medical dispute resolution

internally to the commission. If they are dissatisfied with that they get a de novo hearing at the SOAH, which the court knows is an independent cadre of highly trained and capable administrative law judges. And finally, if they are still dissatisfied with the amount of payment they have judicial review now since this court's decision in Continental Casualty to the DC's of Travis County.

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AMICUS CURIAE

SCHENKKAN: J. O'Neill, your question about do the non-MAR cases under that one provision of the dispute and audit rules present a special problem? Obviously they present more of an issue than most of the rules. For most fees, for most services, for most of these 8,000 CPT codes, the fee is set in the rule. And that's the appropriate payment that the carrier is supposed to make.

O'NEILL: So when it says maximum allowable it doesn't really mean maximum allowable? It means they have to pay that amount.

SCHENKKAN: Actually the rules generally say the lesser of the provider's usual and customary charge, or the MAR. And in most cases really accept for pharmacies the MAR is the lessor, because pharmacies are the only ones that have competition.

So in general the rules read the lessor of the charge or the MAR, but in practice and in all the cases involved in the 1996 fee guideline that we're dealing with here, it's going to turn out to be the MAR.

Then focusing on those services, which the commission has said are too unusual or too variable for them to set a MAR, and where they have told the carrier you have to develop a methodology. It has to be consistent. You have to disclose it in your notice when you deny or reduce payment on the basis of your methodology. What's the reason why if that's a delegation it's not an unconstitutional delegation?

First, I do not concede that it is a delegation. This is a system in which providers do what providers have to do - bill; carriers do what they have to do - review bills. That system would exist under any scenario. And the government regulates every step in the process: the billing, the payment and the dispute. But if, and this is the harder case (this is the one that looks more like a delegation) if you say it's a delegation then what's the safeguard? The safeguard is there is review. But 413.031 of the Labor Code and some of these very dispute and audit rules that the court below held unconstitutional provide that any party specifically including a provider is entitled to review of any carrier reduction, or denial of payment. It's the first step in the process.

PHILLIPS: If we determine that there has been a delegation of governmental power here, do you think that we should consider a different test from Boll Weevil for this because it's a subdelegation from an agency, or if there's a delegation will one size fit all?

SCHENKKAN: I think the Boll Weevil standards are generally the appropriate ones. I think in applying them the court can take some additional comfort when the context is delegation by an agency from the fact that agencies and their decisions are subject to additional review by the courts. Legislative decisions are not. Legislative decisions are essentially only subject to constitutionality review.

Agency decisions, if it's review of the rule as in this case are subject 1) to review for is the rule consistent with the statute? and 2) reviewed for consistency with the rulemaking procedural requirement set up by the legislature. Has the agency given a reasoned justification for making the decisions that it has made in the rulemaking?

If the agency is applying the system, the delegated power through contested cases, those decisions are separately reviewable as the SOAH decisions in this scheme are reviewable.

JEFFERSON: Are they all separately reviewable because of what? What statute gives judicial review?

SCHENKKAN: The labor code was amended in the 2001 session of the Texas Legislature after this court's decision in Functional Restoration Associates v. Continental Casualty, held that there wasn't a specific labor code right of judicial review of these decisions. And the parties hadn't properly preserved the inherent constitutional right of review or the APA right of review issue. The legislature went back and put that into the Labor Code, specifically 413.031(K).

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RESPONDENT

RIGGS: If these rules just directed insurance carriers about how to process bills as the commission in the amicus contends so strenuously in their briefs, then it's hard to see how declaring these rules invalid could possibly eviscerate the entire commission system of reviewing medical services provided by healthcare providers to injured workers.

The heart of this case and the heart of Dr. Meril's concern and PAT concern is whether reasonable health care providers have to guess at whether they will be paid and how much they will be paid before they provide services to injured workers in Texas.

HECHT: How would that be different if the process moved in-house to the commission?

RIGGS: Because in-house it wouldn't have an interested party.

HECHT: You still wouldn't know. You would not have any more information necessarily than you do this way.

RIGGS: Actually we would have more information because under the section for which there is no maximum allowable reimbursement, the one that J. O'Neill was inquiring about, insurance carriers right now apply their own methodology about whether to deny a payment because services are unnecessary. They exercise their own discretion about whether to decide whether services are not related to injury. Those are four situations where the medical fee guideline does establish an MAR. They may apply their own methodology, their own underwriting guidelines, which may be different from carrier to carrier. Where there is a maximum allowable reimbursement they are actually directed in the rules to develop their own methodology. It's not subject to medicine comment rulemaking. And although the worker's comp commission tells them - Carrier be consistent; apply your methodology to similar situations in a consistent manner. There is no requirement that they compare their underwriting guidelines and their methodology to other carriers nor is their any disclosure requirement. If that function were with the commission...

HECHT: Until after the services are rendered? They have to disclose at the time they reject the claim or...

RIGGS: Yes.

HECHT: You mean ahead of time?

RIGGS: Even when they reject the claim they have to give an explanation of benefits. And the explanation of benefits says why we're rejecting. And they can't just say not within guidelines. That's clear. But do they have to actually disclose their methodology? There is no affirmative requirement on them to disclose the methodology. And that's part of our concern. What has been delegated is essentially rulemaking power. Rulemaking power that is not subject to notice and comment review. So there are really different things that actually are delegated. This is not just the review of bills.

What the rules do is allow the carriers to actually make a decision. To make a decision and require that the provider even go through a motion for rehearing process where they submit a request for reconsideration to the carrier and then the carrier can say, Sorry, we're going to stick with our decision. And then the healthcare provider appeals pursuant to 413.031.

Our view is what should happen and what the legislature intended is that the WCC is the arbiter. And that if a carrier says, For our internal reasons we don't want to pay a bill, then what they do is they pay 50% of the amount charged and they seek dispute resolution.

And what I heard Mr. Helmcamp say is, the WCC we can't do this. It would be too expensive. We just don't have the manpower to make these decisions. But unfortunately that's what the legislature has said for them to do, that they are the ones who should be making this decision. And many of our concerns would go away. And I think in fact many of the provisions of these rules would probably not be at issue if it were a neutral party that got to make the decision.

J. Phillips asked Mr. Schenkkan whether a different standard should apply when we're talking about a subdelegation. A different standard from the Boll Weevil standard. Boll Weevil and FM Properties really base their decision on separation of powers. But footnote 10 in the Boll Weevil case in J. Hecht's dissent did go into the issue of due process. And due process is primarily the concern when you have a third party, particularly one with a pecuniary interest making the decisions.

Many of our concerns in this case, and many of the things that the courts have looked at in delegation cases when the court says, Well there are no bright lines, it's really a matter of degree, many of the problems in this case and many of the problems for the healthcare providers would go away if the decision maker were neutral.

HECHT: I'm having trouble following because you say we would be better off if the providers got paid and the carriers had to complain. But why is that any more or less a delegation than if they don't get paid and they have to complain? It looks to me like at some point somebody's got to go to the commission and get it resolved.

RIGGS: Exactly. And it's our view that that's what the whole system is set up to do. The commission...

HECHT: That's what's happening. If you disagree, you go to the commission and get a decision don't you?

RIGGS: No. Because you have an added layer of decision making power. What the commission has done is delegate to the carriers the power to actually make a decision that then the carriers have the burden of appealing under the dispute resolution process.

HECHT: The providers have the burden of proof.

RIGGS: The providers have the burden in every instance. And that shifting of the burden it's not just a matter of delay and expense, although there is substantial expense in delay involved. But it would be akin to a rule of the court telling a plaintiff you don't get to go to court until you first submit to the defendant, say in a personal injury case, your complaint and all your discovery, not just your discovery or what you're going to rely on, but anything the defendant wants to look at, you've got to let the defendant look at it. And then if the defendant says, I don't think your claim states a cause of action, then you have to ask them for reconsideration, and only after you've gone through that whole process can you file your petition in court. That's what we have going on here. And our position is, sure they can disagree with the bill. And if we want to accept what they pay us we go away. And if the WCC medical fee guideline is what it should be, a presumptively reasonable fee, then half the time if that's what they pay the provider is going to know I have to overcome that presumption if I am going to appeal.

HECHT: I can see that it may be a better idea or worse idea for somebody to have the

burden or not to have the burden. But I don't see how that's a delegation because either the bill is presumptively right and the carrier has to go to the commission and complain, or there is some audit involved and the provider has to go to the commission. But somebody's got to go. How does that make that a delegation? That's what I'm missing.

RIGGS: Because they get to make a decision and shift the burden because they actually get to apply their own methodology guidelines and underwriting principles without disclosing them. Because they actually get to develop in the case of the MAR their own underwriting guidelines and apply them.

O'NEILL: That's the focus that I've had is it seems like the big complaint is that the provider is subject to differing methodologies that appear to be fairly random. And there's no vehicle to make them standardized which should be the role of the TWCC plays. It's more of an ad hoc review determination as opposed to the TWCC setting the methodology in the first instance.

RIGGS: That is exactly right. And unlike the 3rd CA's decision in the Office of Public Interest counsel case, this is not a situation where the commission reviews the methodology developed by the carriers. If you look at 133.305, what actually happens in dispute resolution contrary to what counsel says, those rules on their face do not give healthcare providers the opportunity to challenge the methodology. In fact the carriers contend that their methodology and their underwriting guidelines are confidential and are not available under the open records act.

O'NEILL: Is it possible then if a provider does the same service for five different patients, with five different providers, there could be differing fees for all five, and the provider can never know what methodology they use, and so therefore, can never challenge the methodology. They can only challenge the amount on an ad hoc basis.

RIGGS: That is correct. And that's what we believe why there is really no meaningful review. The first test in Boll Weevil for what's occurring here is we don't have a vehicle to challenge the failure to disclose the methodology or to even know what it is. And the issues are very limited in the medical dispute resolution process.

WAINWRIGHT: Ultimately though isn't there an appeal to the SOAH, so that consistent principles, if your complaint is that they are inconsistent before that point, are applied to everyone? Isn't there someone from the WCC or some entity riding herd over the whole process?

RIGGS: There is review. Whether it is adequate, we do not believe it is adequate. The first test of Boll Weevil says it has to be an opportunity from meaningful review. If the provider does not get to know what the standards are, if they are a secret standard applied by the carrier, if they make up the law and then apply the law and we don't get to know what it is in that initial stage, our review of that decision is not going to be a meaningful review. There is a review process, and it is a de novo review in front of the state office of admin. hearings (SOAH). But that's two stages away. And the second test in Boll Weevil is whether you have an adequate representative or you're

adequately represented in the very first hearing process.

And what we're talking about here is the carriers aren't just processing bills. They are authorized to go in and audit. They can do an on-site or a desk audit. A desk audit can sometimes be equally intrusive as an onsite audit. So our concern there as well is that there's a process there and we are not adequately represented in that process. And so it's questionable. The first element I can't say absolutely there is no meaningful review. It's not as meaningful as it should be, but is it as clear cut as the element was in the Boll Weevil case? No.

O'NEILL: I understand the argument about the non-MAR setting being fee setting. What about the MAR situation. I understand that there are guidelines but my understanding of the way it works is, it's a floor unless the provider seeks less. Where is there discretion there with the carrier?

RIGGS: Actually the way the MAR works is it's a ceiling and there is no floor. And that's part of our concern. The TWCC rules do say, Carrier you should pay either the maximum allowable reimbursement or the usual charge whichever is less. But there are many, many ways under the rules where the carriers could come in and say that a particular service is not medically necessary. So the fact that there has been a fee set for it it still leaves them the room to apply their discretion and to decide whether it's medically necessary. And in that process, and in the process that's established in these rules we don't really get to know who makes that decision. Do we know whether for example a spine surgeon is reviewing the bills of a spine surgeon? Do we know whether a spine surgeon with the insurance carrier is in fact deciding whether a particular surgery was medically necessary?

O'NEILL: If it's determined that it's not medically necessary do they just deny it or do they adjust the fee?

RIGGS: Actually they cannot - they will deny it.

O'NEILL: So it can't really be fee setting?

RIGGS: I see the distinction, and that is different from fee setting, but it is still applying their discretion to decide whether a fee will be paid. Which gets back to, Aren't my clients entitled to know what standards will guide whether they are being paid much less how much? Because many of the problems here are with preauthorization decisions, and whether ancillary services will be allowed. Medical necessity is at the heart of many of the medical fee dispute cases. There are statistic cited in the TWCC brief and in amicus briefs that demonstrate the number of claims that deal with medical necessity, because that is the vehicle that's used by the carriers using their own standards, which may vary from carrier to carrier, to deny reimbursement.

PHILLIPS: Can you briefly contrast this system with medical providers' remedies and obligations in private contracting for services particularly where the patient has private insurance?

It sounds to me like a lot of what you're complaining about is endemic to 21st century healthcare.

RIGGS: There's a big difference. And that's because in a private care situation there are different remedies. And if a carrier has a contract, and if a provider is providing services say in a managed care context, the carrier and the provider can argue as they wish. Whatever the contract says they can - if it requires them to engage in alternative dispute resolution, if it requires them to submit information to the carrier that's a matter of contract. But what we have here is a statutory entitlement to payment under 413.01(1) for fair and reasonable reimbursement for services that are provided. All three of the factors are relevant, not just fair and reasonable. But access to quality medical care and cost containment.

So we have a statutory right. It's very different than when a healthcare provider is negotiating with a provider. And a provider as the amicus acknowledges they don't have to provide insurance to employers in Texas. But once they do under the statute that has been cited numerous times by counsel, 408.027, they shall pay the fee allowed under 413.011. So they have a statutory obligation to pay the fees. The commission is the one that sets the fees and it is the commission that is the one that establishes what should be the _____ application of the methodology and developing the methodology for fair and reasonable fees.

PHILLIPS: You don't contend that the commission could set MARS in advance for every conceivable procedure?

RIGGS: No.

PHILLIPS: There has to be a system when something has been done that isn't routinely done.

RIGGS: Exactly. And I think there are ample cases that deal with situations in which ad hoc rulemaking is appropriate. But in this area there are national - the code of procedural terminology does establish standard values for particular services and even establishes the various different geographic regions where there may be variances in health care costs. So we would be better off if they in fact did set fees. And of course that gets to our argument that they do not in fact have the authority to set fees and that what this court should do is say that if that's in fact what they are trying to do, they have to have express statutory authority to in fact set fees.

What they currently have the authority to do is very similar to that which according to the _____ Defabaugh(?) case that they have the authority to establish presumptively reasonable fees. But what they have in fact done is ratemaking and it's our position that when they engage in ratemaking, we should have a contested case procedure so you can ascertain the facts and develop an evidentiary record to justify the amount of fees.

HECHT: And you don't think you can raise that in a complaint about a particular bill? Can't you just go in and say this is an unreasonable low amount for this service?

RIGGS: And providers do it. I believe some of the statistics show 4,800 times in 2002.

HECHT: The first half, I think it was.

RIGGS: Yes. They do that.

HECHT: What about half the time according to the statistics?

RIGGS: And they do that very often. Many, many do not. If you look at the total volume of bills that are processed the number of times when there are contests are limited. But there are also situations in which do we want to have a situation where healthcare providers are leaving.

HECHT: Would you be satisfied from the delegation point of view, not the other arguments that you make, if the commission had a rule that said, Ok, provider sends the carrier a bill, the carrier just says yes or no. And if the carrier says no, then the provider has to come to the commission and say we want the money, and then we're going to have a hearing and we're going to ask the carrier why won't you pay this. And the carrier's going to say because this is the way we audit bills. And they will have a hearing about that and then there will be a decision one way or the other. Would that satisfy the delegation concerns?

RIGGS: I think what would satisfy the delegation concerns and the statutory authority concerns is what is expressly stated in 408.027. They either pay it or if the carrier doesn't want to pay it, then they show why - they have the burden of showing why to the commission it should not be paid.

HECHT: So the crux of the argument is, that because the burden is on the provider to go to the commission that's the delegation?

RIGGS: That's part of the delegation. Part of it of course is the MAR and the development of the methodologies and applying the law to particular individuals as the court rejected in both Boll Weevil and the FM Properties case.

HECHT: You have a number of other arguments that you raised in the CA that the court did not need to address because of their view of the delegation. And you still urge those arguments.

RIGGS: Yes we do. Very strenuously.

WAINWRIGHT: You mentioned earlier that not having what you called an objective party involved to provide what might be a reasonable payment for a service, you called it the conflict of interest. Is the source of many of your concerns with the delegation. Is that the linchpin of your concern and the linchpin of your argument this conflict situation...SIDE A RUNS OUT

SIDE B

RIGGS: ...decision on separation of powers rather than due process, but did discuss the due process elements. And I think we did raise due process in the TC. And I think due process is an element of the delegation of the nondelegation doctrine. And I think that is what makes a delegation to a private entity more onerous and subject to heightened scrutiny. And here we think it should be an even more heightened scrutiny because it is not even a legislative delegation to carriers.

What we have here is a subdelegation by the commission to the private entity. So it's not even a legislative enactment. So we do believe that due process requires an even more heightened standard and that underlies many of our concerns.

The exercise of discretion by one with a pecuniary interest is what makes the delegation most objectionable.

WAINWRIGHT: If your conflict concern is resolved against you do you necessarily lose that part of the argument?

RIGGS: Absolutely not. There are still a number of other elements under the Boll Weevil test which are still established. And as the court has said, we don't have to meet all 8, you don't even have to consider all 8, you have to look at all of the factors and apply all of them.

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REBUTTAL

HELMCAMP: There were several misstatements that have been made, and I think maybe more accurately a missimpression that's been left by what's going on here.

I need to come back to J. O'Neill's question about the 5 different patients, by the same doctor with 5 different patients, covered by 5 different carriers. The impression may have been left with you that in all situations there is going to be 5 different payments. If it is one of those 8,500 medical procedures for which the commission has painstakingly established a maximum allowable reimbursement level, those 5 patients for that one physician will be paid at exactly the same rate. There is no secret methodology. That is simply a red herring.

O'NEILL: I think the premise of the question was strictly non MAR payments.

HELMCAMP: Only in the non MAR situation may there be differing payments by differing healthcare providers. But that does not constitute an improper delegation because each one of those 5 situations on those 5 patients must meet the statutory standards of fair and reasonable, etc. that we've talked about before. And most importantly, is...

O'NEILL: What's fair and reasonable is going to be different according to how each carrier internally factors their methodology, which no one ever knows.

HELMCAMP: And that's a misnomer too. But first, the payment will be fair and reasonable as ultimately judged by the commission at medical dispute resolution, next by SOAH, if a dissatisfied party goes there...

O'NEILL: You seem to say that review fixes it all. But my understanding of the review is unpredictable because the methodologies are unknown and you can't get to the methodologies, and so therefore, it's this random sort of review.

HELMCAMP: And that's just not true. This is provided under Tab 4 of the Judge's book that was provided to you. It's 133.304(I)(2). It specifically says when the insurance carrier pays a healthcare provider for treatments and/or services for which the commission has not established a maximum allowable reimbursement, the insurance carrier shall 1) develop and consistently apply a methodology to determine fair and reasonable; most importantly 2) explain and document the method it used to calculate the rate of pay and apply this method consistently.

So it is simply incorrect to say that they don't know what the methodology is, because there is always discovery. But more importantly by rule the commission has exercised that governmental control to make sure that there is no secret rulemaking and no hidden underwriting decisions. That's just simply not the case.

We haven't really said much about the validity of the medical fee guideline and really the one year rule. The CA absolutely on these two points got it right. The commission complied more than substantially...

HECHT: What has happened with the rule since the CA's decision?

HELMCAMP: Healthcare providers, some of them around the state of Texas have interpreted the CA's decision in this case as virtually wiping out any ability of an insurance carrier to review a medical bill. They have taken the position that they may proceed from anytime an insurance carrier or other payor denies them payment, they may proceed directly to any court in the state of Texas, file suit on an unpaid debt, thereby, failing to exhaust administrative remedies. And that's one of the things that has really happened over the misapplication and misunderstanding of the statutory principles by the CA.

HECHT: And you agree that there are other, or do you, constitutional issues that the CA did not need to address and would have to be addressed before the respondent's position...

HELMCAMP: I do. And that's the unfortunate thing about the time we have allowed for oral argument. It is what it is and we do the best we can to answer your questions and raise the points that we think are important. What I can say to you in closing is, there's been enormous briefing done on this case by amicus, by the parties themselves. There's also an enormous amount of statutory material. You really need as you grapple with these constitutional issues, not just the one's we've argued, but the one's we haven't, take a look at the statutory provisions that are cited for you in our

briefs. Take a look at the rules themselves: 133.301 to 133.305. You will see that what those rules do is they regulate with great specificity how insurance carriers and other payors shall do their business, and they delegate nothing.