Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL TIDWELL
C/O HOLLAWAY & GUMBERT
SUITE 1288
3701 KIRBY DRIVE
HOUSTON TX 77098

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-04-9509-01

MFDR Date Received
May 21, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier paid a total of $159.07 in connection with this claim alleging payment to be 'fair and reasonable.' It is our position that reimbursement was neither fair nor reasonable pursuant to Rules 134.401 (a) (4) and 134.600 of the Texas Workers' Compensation Commission ('TWCC'). Fees for goods and services provided by Doctors Hospital Tidwell Parkway are based upon the rates that the market will bear in the geographic locale of the hospital. As with any other widespread industry, the prices, which the hospital must charge for its goods and services, are affected by market forces beyond its control, including but not limited to the costs for raw materials, labor, and transportation of goods and supplies. Doctors Hospital Tidwell Parkway is a general hospital and is licensed as such by the state of Texas. The hospital operates 24 hours a day, 365 days per year, and is expected to deliver nothing less than excellence in medical care, services and facilities at all times. Fees are set based upon the cost factors described above, as well as the cost maintaining the physical plant of the hospital, including but not limited to highly trained [sic] nursing and administrative personnel... It is our contention that reimbursement by the carrier at a rate of approximately fourteen percent (14%) of the Hospital's standard charges does not constitute 'fair and reasonable' reimbursement, especially in light of the hospital setting the services were provided in."

Amount in Dispute: $997.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the requester has been reimbursed a fair and reasonable reimbursement based on the 04-01-96 TWCC Medical Fee Guideline maximum allowable reimbursement. The 04-01-96 TWCC Medical Fee Guideline, is required to be fair and reasonable per Section 413.011 (d) which states, 'Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control....' The venipuncture charge is global to the laboratory test reimbursement, therefore, no additional reimbursement is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2003	Outpatient Hospital Services	$997.93	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on May 21, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on May 26, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed.
   - YG – Reimbursement for this procedure is included in the basic allowance for another procedure.
   - YS – Supplemental payment.
   - RD – The reimbursement for the services rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with labor code 413.011(B).
   - INT – Interest payment.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. 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. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. Former 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g) (3) (C) (IV).
4. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "Fees are set based upon the cost factors described above, as well as the cost maintaining the physical plant of the hospital, including but not limited to highly trained nursing and administrative personnel..."
   - The requestor does not discuss or explain how the cost factors support the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.

- The Division has previously found that a reimbursement methodology based on hospital costs does not produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division, as stated in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble:

  > The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models . . . are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs. . . . Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs. (22 *Texas Register* 6276)

  Therefore, a reimbursement amount that is calculated based upon a hospital's costs cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 28, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.