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
MAINLAND MEDICAL CENTER

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-06-2333-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
November 29, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "IC failed to pay claim at fair and reasonable rate as required by 134.401(a)(3) IC's payment does not compensate HCP its cost for services rendered; IC's payment is neither fair nor reasonable."

Amount in Dispute: $586.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The office will maintain that reimbursement was made in accordance with Medicare's Trailblazer Clinical Lab fee schedule. The office will maintain denial for 36415 as it is not a reimbursable code through the Clinical Lab fee schedule."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, Texas 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2004	Outpatient Hospital Services	$586.71	$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. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 105 – Additional information needed to review charges
   - 130 – Services unsubstantiated by documentation
   - N – N-Not Appropriately Documented
   - 506 – Re-evaluated bill, payment adjusted
   - B15 – Procedure/Service is not paid separately
   - TC – Technical Component

- W10 – Payment based on fair & reasonable methodology
- W4 – No additional payment allowed after review

Findings

1. This dispute relates to outpatient hospital 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."

   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.
2. 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 has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "IC failed to pay claim at fair and reasonable rate as required by 134.401(a)(3) IC's payment does not compensate HCP its cost for services rendered; IC's payment is neither fair nor reasonable."
   - The requestor did not discuss or submit documentation to support the amount of its costs for the disputed services.
   - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline,* that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269). Therefore, the use of a hospital's "usual and customary" charges 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 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.

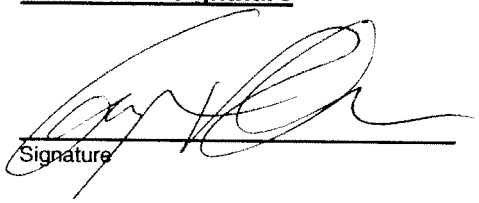
Conclusion

For the reasons stated above, the Division finds that 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

Grayson Richardson
Medical Fee Dispute Resolution Officer

5/2/2014
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.