Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-06-2603-01
VISTA MEDICAL CENTER HOSPITAL 4301 VISTA RD PASADENA TX 77504	DWC Claim #:
	Injured Employee:
Respondent Name and Carrier's Austin Representative Box #:	Date of Injury:
HARRIS COUNTY HOSPITAL DISTRICT Box #: 21	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Medical Center Hospital charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract."

Amount in Dispute: $12,503.95

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regarding the dates-of-service complained of by the Requestor, Respondent asserts it paid a fair and reasonable rate to the Requestor for all services rendered to the Claimant, per Tex. Labor Code §413.011(b). The Requestor has not met its burden to prove its bills were within the parameters contemplated by the Act, and thus merits no further reimbursement."

Response Submitted by: Harris & Harris, Attorneys At Law, P.O. Box 162443 Westlake Station, Austin, TX 78716

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
04/07/2005	150, 426, 429, 97, 217, 24	Outpatient Surgery	$12,503.95	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on December 6, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor December 21, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - 150 – PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITED DOES NOT SUPPORT THIS LEVEL OF SERVICE
   - 426 – REIMBURSED TO FAIR AND REASONABLE
   - 429 – REDUCTIONS ARE DUE TO CHARGES EXCEEDING AMT$ REASONABLE FOR PROVIDERS DEMOGRAPHIC AREA. PLEASE DIRECT QUESTIONS TO QM6OTRIX 800/833-1933.
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE. 05119008300
   - 24 –PAYMENT FOR CHARGES ADJUSTED. CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN.
2. The respondent denied disputed services with reason code 150 – "PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITED DOES NOT SUPPORT THIS LEVEL OF SERVICE." Division rule at 28 TAC §133.300(c) states that "Upon receipt, an insurance carrier shall evaluate each medical bill for completeness as defined in §133.1 of this title (relating to Definitions for Chapter 133, Benefits--Medical Benefits). (1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill. (2) Within seven days after the day it receives an incomplete medical bill, an insurance carrier shall: (A) complete the bill by adding missing information already known to the insurance carrier; (B) contact the sender by telephone, facsimile, or electronic transmission to obtain the information necessary to make the bill complete and make the changes to the bill based on the information the sender provides; the insurance carrier shall document the name and telephone number of the person who supplied the information; or (C) if unable to complete the bill by adding missing information already known to the insurance carrier or contacting the sender, return the bill to the sender, in accordance with subsection (d) of this section." Division rule at 28 TAC §133.1(a)(3)(D) states that a complete medical bill "contains supporting documentation when such documentation is specifically required by Commission rules or guidelines, unless the required documentation was previously provided to the insurance carrier or its agents." No documentation was found to support that the carrier returned the bill to the provider as incomplete. Nor did the respondent support that the provider failed to submit documentation required by Commission rules or guidelines. The respondent did not present to requestor what information was not documented that was necessary to determine a fair and reasonable reimbursement for the services in dispute. This denial reason is not supported. The disputed services will therefore be reviewed per applicable rules and fee guidelines.
3. According to the explanation of benefits dated 05/10/2005 the carrier reduced the medical bill because 24 – "PAYMENT FOR CHARGES ADJUSTED. CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN." 28 Tex. Admin. Code §133.3 requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." The division finds that the denial reason is generic because it does not identify whether a contract was accessed, nor does it identify the network if indeed a discount was taken due to a contract. There is no clear indication that a managed care reduction took place on the EOB on the "Other" column as the same service 94799 was reduced for other reasons as well (see 429). The respondent did not clarify or otherwise address the 24 claim adjustment code on the EOB or upon receipt of the request for dispute resolution. The requestor states that the "Carrier does not have a negotiated contractual agreement with the Healthcare Provider." For this reason, the division finds that the 24 claim adjustment code is not supported.
4. This dispute relates to services with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 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."
5. 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.
6. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 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 asserts that "Vista Medical Center Hospital charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services."

- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The Division has previously found 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," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 TexReg 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.
- In the alternative, the requestor asks to be reimbursed a minimum of 70% of billed charges, in support of which the requestor states that "The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract…It also shows numerous Insurance Carriers' willingness to provide 70% reimbursement for Out-Patient Hospital setting medical services."
- The requestor did not submit a copy of the alleged contract for review.
- The requestor has provided select exhibit pages from the alleged managed care contract referenced above; however, a copy of the contract referenced in the position statement was not presented for review with this dispute.
- Review of the exhibit pages submitted by the requestor finds a schedule of charges, labeled exhibit "A", dated 04/23/92, which states that "OUTPATIENT SERVICES: 101/401 PAY 70% OF BILLED CHARGES."
- The requestor submitted a letter of clarification dated July 30, 1992 indicating a change in reimbursement to the above referenced contract, stating in part that "services rendered to eligible Beneficiaries will be considered at 80% of the usual and reasonable charge which is equal to the <u>lesser of</u> the actual charges billed by HCP; <u>OR</u> the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research Database."
- The requestor submitted a fee schedule page, labeled exhibit A, dated effective August 1, 1992 which states, in part, that the provider shall receive "an amount equal to eighty percent (80%) of the Usual and Reasonable Charge for those Covered Services. For all purposes hereunder, the Usual and Reasonable Charge for such services shall be equal to <u>the lesser of</u>: (i) the actual charges billed by HCP for such services; or (ii) the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research database."
- No data or information was submitted from the Medical Data Research database to support the requested reimbursement.
- No documentation was presented by the requestor to support that the referenced contract was in effect at the time of the disputed services.
- The requestor's position statement further asserts that "amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, the Division stated specifically that managed care contracts fulfill the requirements of Texas Labor Code § 413.011 as they are 'relevant to what fair and reasonable reimbursement is,' they are relevant to achieving cost control,' they are relevant to ensuring access to quality care,' and they are 'highly reliable.' *See* 22 TexReg 6272. Finally, managed care contracts were determined by the Division to be the best indication of a market price voluntarily negotiated for medical services."
- While managed care contracts are relevant to determining a fair and reasonable reimbursement, the Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 Texas Register 6276 (July 4, 1997) that:

  > "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

  Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed 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.

- In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or 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 Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor 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.

7. 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, and the thorough review and consideration of that evidence. After thorough review and consideration of all 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 Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §133.300, and §133.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

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 not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

		07/21/11
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (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. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

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