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

EAST TEXAS MEDICAL CENTER TYLER
C/O FRANCIS ORR & TOTUSEK LLP
500 N AKARD ST STE 2840
DALLAS TX 75201

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
EAST TX EDUCATIONAL INS ASSN

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-06-2772-01

MFDR Date Received
DECEMBER 16, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On January 7, 2005, [injured employee] was severally injured when his vehicle collided head-on with an eighteen wheel truck. [Injured employee] was taken to an emergency room in Nacogdoches. Because the severity of his injuries required a higher level of care than could be provided in Nacogdoches, [injured employee] was then transferred, by helicopter, to ETMC in Tyler for further treatment and evaluation. [Injured employee] was treated in the Medical Center for 18 days, 8 of which were in the ICU, with a primary diagnosis code of 82310, multiple trauma. During his stay at the Medical Center, the Patient underwent five (5) surgeries that included at least twelve (12) significant procedures including 'limb reattachment, hip and femur'. . . . According to Commission Rule 134.401 Acute Care Inpatient Hospital Fee Guidelines for Patient's treated for a primary diagnosis code of 82310, this Account should be reimbursed based upon a fair and reasonable rate. ETMC disputes the carrier's reimbursement in the amount of $70,832.58 as fair and reasonable, particularly given the unusually extensive nature of the Patient's injuries, the unusually extensive services provided to the Patient, the Patient's length of stay, the number of days the Patient spent in ICU, the five (5) surgeries and twelve (12) significant procedures performed on the Patient. . . . The Medical Center's position is that the total billed charges $248,540.50 are fair and reasonable charges for the unusually extensive services, level of care, and treatment it provided to [injured employee]. In addition, pursuant to a network agreement, the carrier may be entitled to a 15% managed care discount. . . . In the alternative, the Medical Center should at least be reimbursed pursuant to Rule 134.401(c)(6), the Stop-Loss Method which was '…established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.' Under the Stop-Loss Method, the provider is reimbursed at the rate of 75% of billed charges, for claims which exceed $40,000.00 in billed charges and involve 'unusually extensive services'. The Medical Center's charges exceed $40,000.00 and the Medical Center has substantiated the 'unusually extensive services' provided to [injured employee]."

Amount in Dispute: $140,426.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because ETMC submitted what appeared to be excessive charges totaling $248,540.40 for [injured employee's] treatment, Health E Innovations submitted the bills to FairPay Solutions, Inc. f/k/a Mednet Connect ('FairPay') for a specialty audit. Following this objective, comprehensive audit, FairPay recommended payment of $67,352.51. It is FairPay's position that the no additional reimbursement is due at this time, as the recommendation represents a fair and reasonable reimbursement for the services rendered."

Response Submitted by: FairPay Solutions, Inc., 114295 Midway Road, Suite 300, Addison, TX 75001

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 7, 2005 through January 25, 2005	Inpatient Services	$140,426.84	$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 §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CL1 – Processed per client guidelines.
   - M – No MAR.
   - TR1 – Acute trauma care reimbursed to a standard of reasonableness for usual and customary.
   - 426 – Reimbursed to fair and reasonable.
   - 249 – See note below. . . .These services were reviewed by an outside vendor and reimbursed to a standard of reasonableness for usual and customary. A copy of their review has been enclosed.
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - F – Fee guideline maximum allowable reimbursement reduction.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 876 – Reimbursement equals the amount billed.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 1123 – We are unable to process the provider's re-billing, as the documentation does not specify the concern regarding the original analysis. Please re-submit with a clarification for the basis of the reconsideration.

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Contract/Legislated Fee Arrangement Exceeded." Additionally, the requestor's position statement asserts that "pursuant to a network agreement, the carrier may be entitled to a 15% managed care discount**."** Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a managed care discount, network agreement, or contractual fee arrangement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 823.10. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

3. Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(d) which states that "Fair and reasonable reimbursement: (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."

4. 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.

5. 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 asserts that "the total billed charges $248,540.50 are fair and reasonable charges for the unusually extensive services, level of care, and treatment it provided . . ."
   - 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 *Texas Register* 6276. 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 *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 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 based on the total billed charges 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.

6. In the alternative, the requestor states "pursuant to a network agreement, the carrier may be entitled to a 15% managed care discount. . . . Based on total charges of $248,540.50, less a 15% manage care discount, the Medical Center should be reimbursed as follows: . . . Remaining Amount due ETMC <u>$140,426.84</u>." Review of the submitted documentation finds that:

   - As stated above, review of the submitted information finds insufficient documentation to support that the disputed services are subject to a managed care discount, network agreement, or contractual fee arrangement between the parties to this dispute.
   - The requestor did not discuss, demonstrate or provide documentation to support that total charges less a 15% discount would provide a fair and reasonable reimbursement for the services in dispute.
   - 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 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.
   - The requestor did not submit documentation to support that payment of the alternative amount of $140,426.84 would be a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of this alternative amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for alternative reimbursement in the amount of $140,426.84 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.

7. In the alternative, the requestor states that "the Medical Center should at least be reimbursed pursuant to Rule 134.401(c)(6), the Stop-Loss Method which was '...established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.' Under the Stop-Loss Method, the provider is reimbursed at the rate of 75% of billed charges, for claims which exceed $40,000.00 in billed charges and involve 'unusually extensive services'. The Medical Center's charges exceed $40,000.00 and the Medical Center has substantiated the 'unusually extensive services' provided . . . Therefore, in the alternative, ETMC should at least be reimbursed as follows: . . . Remaining Amount due ETMC $115,572.79." Review of the submitted documentation finds that:

   - As noted above, 28 Texas Administrative Code §134.401 is not applicable to the services in dispute, the applicable rule for reimbursement is 28 Texas Administrative Code §134.1.
   - Moreover, per §134.401(c)(6), "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a diagnosis code specified in §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.
   - 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 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.
   - The requestor did not submit documentation to support that payment of the alternative amount of $115,527.79 would be a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of this alternative amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for alternative reimbursement in the amount of $115,527.79 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.

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, 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 amounts 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. 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.

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

		December 27, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		December 27, 2012
Signature	Director, Health Care Business Management	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.