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

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-08-2776-01

MFDR Date Received
January 7, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."

Amount in Dispute: $269.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier denied reimbursement for the charges assessed by Renaissance Hospital in the above referenced matter contending, among other things, that the services were not provided by the appropriate healthcare provider. There are no allegations in this matter that the services . . . were provided by the treating doctor or at the referral of the treating doctor, as required by the applicable statutory and regulatory provisions."

Response Submitted by: Burns Anderson Jury & Brenner LLP, 784 Bell Mountain Dr, Ste. 100, Austin, Texas 78730

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2007	Emergency Room Services	$269.03	$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 §133.2 defines words and terms related to medical billing and processing.
3. 28 Texas Administrative Code §180.22 establishes heath care provider roles and responsibilities.

4. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
5. 28 Texas Administrative Code §134.403 sets out the fee guideline for acute care outpatient hospital services.
6. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
7. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
8. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
9. By letter dated August 4, 2011, the attorney for the requestor provided *REQUESTOR'S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – DALLAS)* that specified, in pertinent parts, an "Additional Reimbursement Amount Owed" of $536.89 and an "alternative" "Additional Reimbursement Amount Owed" of $209.66. The Division notes that the amount in dispute of $269.03 specified above is the original amount in dispute as indicated in the requestor's *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR'S AMENDED POSITION STATEMENT*.
10. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - 075-001 – 450 THE ALLOWANCE FOR THIS CODE HAS BEEN INCLUDED IN THE ALLOWED AMOUNT IN EXPLANATION CODE 080-001.
    - 080-001 – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT FOR THE ENTIRE BILL OF $0.00
    - 112-003 – THE PRIMARY PROVIDER IS A NON-CONTRACTED PROVIDER.
    - 147 – Provider contracted/negotiated rate expired or not on file.
    - 170 – Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
    - 910-102 – NOT APPROPRIATE HEALTH CARE PROVIDER
    - 94 – Processed in Excess of charges. $0.00
    - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
    - 38 – Services not provided or authorized by designated (network/primary care) providers.
    - 900-001 – O-DENIAL AFTER RECONSIDERATION BASED ON FURTHER REVIEW, NO PAYMENT IS WARRANTED.
    - W1 – Workers Compensation State Fee Schedule Adjustment $0.00
    - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. The insurance carrier denied disputed services with reason codes: 112-003 – "THE PRIMARY PROVIDER IS A NON-CONTRACTED PROVIDER"; 147 – "Provider contracted/negotiated rate expired or not on file"; and 38 – "Services not provided or authorized by designated (network/primary care) providers" No documentation was found to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on June 29, 2011, the Division requested the respondent to provide a copy of the referenced contract(s) between the network and the requestor, pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31 Texas Register 10314, which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." Technical Operations Manager Wayne T. Gill of Broadspire, as third party administrator, responded on behalf of the insurance carrier by letter dated July 6, 2011, which stated that "After review, it has been determined that no informal/voluntary network contract existed for this date of service." Review of the submitted information finds that a contractual fee arrangement is not supported between the parties to this dispute. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. The respondent's position statement asserts that "based on records received, it appears that Claimant was going to the hospital to obtain drugs that her treating doctor or his designee would no longer prescribe." The Division notes that the respondent has not raised any issues of medical necessity regarding the disputed services. Nor are there any unresolved issues regarding compensability, liability or extent of injury related to this medical fee disputed, as the respondent has indicated by checking the appropriate box on the DWC060 form submitted with their response. 28 Texas Administrative Code §133.307(d)(2)(B), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented this denial reason to the requestor prior to the date that the request for medical dispute resolution was filed with the Division. Accordingly, any newly raised denial reasons or defenses shall not be considered in this review.

3. The insurance carrier denied disputed services with reason codes: 170 – "Payment is denied when performed/ billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."; 910-102 – "NOT APPROPRIATE HEALTH CARE PROVIDER"; and 38 – "Services not provided or authorized by designated (network/primary care) providers." The respondent's position statement asserts that " the services were not provided by the appropriate healthcare provider. There are no allegations in this matter that the services . . . were provided by the treating doctor or at the referral of the treating doctor, as required by the applicable statutory and regulatory provisions." 28 Texas Administrative Code §180.22(c), effective August 16, 2006, 31 *Texas Register* 6370, states, in pertinent part, that:

   > The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's (employee) compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care rendered to the employee including, but not limited to, medically reasonable and necessary treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers

   28 Texas Administrative Code §133.2(3)(A), effective May 2, 2006, 31 *Texas Register* 3544, states that:

   > a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part.

   The Division notes that the rule does not require that the patient actually be in jeopardy or suffer serious dysfunction; rather, it is only required that the patient manifest acute symptoms of such severity (including severe pain) that the health care provider, prior to treatment and without the benefit of hindsight, could reasonably expect the patient to be in jeopardy or to suffer serious dysfunction without further attention. Review of the submitted information finds that:

   - The patient presented for treatment at an emergency room.
   - The patient manifested sharp pain in the back with radiation to the left leg.
   - The pain level was documented at 8/10.
   - The exacerbation of back-pain is documented as acute.

   The Division finds that the submitted documentation supports the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of a body organ or part. Having demonstrated a case of emergency, the requestor has met the exception to the requirement that the treating doctor shall approve or recommend all health care rendered to the injured employee. The Division concludes that the respondent's denial reasons are not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

4. This dispute relates to emergency room services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(a)(5), "Emergency services that do not lead to an inpatient admission are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services."

5. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, 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."

6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's amended position statement asserts that "the fair and reasonable reimbursement amount for this hospital outpatient admission should at least be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."
   - In support of the requested reimbursement methodology the requestor states that "Ordering additional reimbursement based on the average amount paid system-wide in Texas achieves effective medical cost control because it prevents overpayment... creates an expectation of fair reimbursement; and . . . encourages health care providers to continue to offer quality medical care to injured employees . . . Ordering additional reimbursement for at least the average amount paid for a hospital outpatient admission during the same year of service and involving the same Principal Diagnosis Code and Principal Procedure Code ensures that similar procedures provided in similar circumstances receive similar reimbursement . . . The average amount paid for similar admissions as put forward by the Requestor is based on a study of data maintained by the Division."
   - Review of the submitted medical bill and the submitted medical records finds no principal procedure code listed for the services in dispute.
   - Review of the submitted documentation finds insufficient information necessary to calculate a reimbursement amount under the methodology proposed by the requestor.
   - The requestor has not supported that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

   The request for additional reimbursement of the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as the disputed admission for those admissions involving the same principal diagnosis code and principal procedure code is not supported. The requestor has not demonstrated or presented sufficient documentation to support that the additional amount sought is a fair and reasonable rate of reimbursement for the services in dispute.

7. In the alternative, the requestor proposes that "the Hospital Facility Fee Guideline – Outpatient reimbursement formulas offer an objective calculation methodology to determine the fair and reasonable reimbursement amount for this admission." Review of the submitted documentation finds that:
   - In support of the alternative requested reimbursement methodology the requestor states that "The data necessary to calculate the Maximum Allowable Reimbursement for this year of services is readily available from the Medicare Outpatient Prospective Payment System. Therefore, the new fee guidelines as adopted in 28 Tex. Admin. Code § 134.403 provide a presumptive measure of the fair and reasonable reimbursement amount."
   - The requestor did not submit documentation to support the Medicare payment amount for the disputed services.
   - The fee guidelines as adopted in 28 Texas Administrative Code §134.403 were not in effect during the time period when the disputed services were rendered.
   - The Division disagrees that the Hospital Facility Fee Guideline – Outpatient, as set forth in §134.403, provides a presumptive measure of the fair and reasonable reimbursement amount for dates of service prior to the date the rule became effective. No documentation was found to support such a presumption.
   - While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284), Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d) . . . This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."
   - The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in 28 Texas Administrative Code §134.403, effective for dates of service on or after March 1st, 2008, would provide for fair and reasonable reimbursement of the disputed services during the time period that treatment was rendered to the injured employee.
   - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the alternative requested reimbursement.

- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for an alternative reimbursement amount calculated based on the formulas in the Hospital Facility Fee Guideline – Outpatient, as set forth in §134.403, is not supported. The requestor has not demonstrated or presented sufficient documentation to support that the alternative additional amount requested would provide 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 not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

	Grayson Richardson	October 16, 2013
Signature	Medical Fee Dispute Resolution Officer	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.