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's Name and Address:	MFDR Tracking #:	M4-08-4530-01
SPINE HOSPITAL OF SOUTH TEXAS 18600 N HARDY OAKS BLVD SAN ANTONIO TX 78258		
Respondent Name and Box #:		
City of San Antonio Box #: 42		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We have included copies of recent Workman Compensation Explanation of Benefits reimbursements showing fair and reasonable compensations for the same procedure performed in our facility for other patients during this time period. As you can see from these statements, we have been receiving 80% to 95% reimbursements for our services."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $1379.62
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The procedure at issue, completed and billed on an out-patient basis, could have been performed and billed on an in-patient basis, for a considerably lower cost. The in-patient reimbursement for this procedure would include pre-operative care, completion of hospital records, the initiation of treatment, any anesthesia, the entire surgical procedure, and any post-operative care that would follow the specific surgical procedure. If the injured worker had undergone the procedure in an in-patient setting, the quality of care (i.e. around-the-clock nursing care) would have, without question, been greater than that received on an out-patient basis. The records show that the injured worker left the same day as the injection and billed $2,2,97.62 [sic] when a two-day stay in a hospital would cost only $2,236.00. If the same procedure had been performed on an inpatient basis, the facility would receive $1118.00. This provider was reimbursed at two times that rate. This is not cost effective or reasonable or necessary. Reasonable reimbursement for a surgical procedure performed in an out-patient setting should not exceed the costs of a more extensive, in-patient procedure, and in fact should be less."…

"The requestor attempts to justify its bills by supplying different EOBs from other carriers which claim a higher payment rate. These EOBs do not rise to the standard of proof that demonstrates the reasonableness of the fee. Simply 'cherry-picking' and choosing only a bill which was reimbursed at a higher rate to justify a fee fails to justify a fair and reasonable rate of payment. "…

"Respondent asserts it paid a fair and reasonable rate to the Requestor for the surgery. Respondent paid $1,118.00 for this date-of-service. This fee would be the same fee charges by and inpatient hospital facility if the procedure lasted less than one day."…

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS				
Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
12/10/2007	97, W10, DO, W4	Outpatient Surgery	$1,379.62	$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 *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 97 – "Payment is included in the allowance for another service/procedure."
   - W10 – "No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology."
   - DO – "Payment is denied as our records indicate that this is an exact duplicate charge for a service that has already been paid or is in process."
   - W4 – "No additional reimbursement allowed after review of appeal/reconsideration."
2. Upon reconsideration the insurance carrier denied payment for these services with the explanation code DO – "Payment is denied as our records indicate that this is an exact duplicate charge for a service that has already been paid or is in process." Review of the documentation finds that the services were resubmitted as a request for reconsideration. The respondent did not submit evidence of duplicate billing or of duplicate payments. This denial reason is therefore not supported.
3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which 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. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "a copy of all medical bill(s)"… "as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter"… Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier and as submitted for reconsideration. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(A).
6. Division Rule at 28 TAC §133.307(c)(2)(G) , effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, 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"... The requestor has not stated explicitly what method should be used to determine a fair and reasonable rate of reimbursement. Although the requestor states "we have been receiving 80% to 95% reimbursements for our services", the requestor does not offer a methodology of its own for consideration. Review of the *Table of Disputed Services* finds that the amount that the requestor lists as the "MAR" for each disputed service is the same as the billed charge, and the amount in dispute for each service is the billed charge less the amount previously paid for each service. The Division notes that there is no MAR for these services per 28 TAC §134.401(a)(4), effective August 1, 1997,22 TexReg 6264, which states, in part, that "outpatient surgical care is 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 types of reimbursements." However, a reimbursement methodology based upon payment of the hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in another fee guideline adoption preamble 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." Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment in the amount of the provider's billed charges, or in the alternative 95% of the billed charges, or in the alternative 80% of the billed charges, would be a fair and reasonable rate of reimbursement for the services in dispute.

7. Further review of the documentation submitted by the requestor finds that the requestor has not addressed how payment of the amount sought would meet the requirements of 28 TAC §134.1 and Texas Labor Code §413.011(d). The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.

8. 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 that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof 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
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR 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.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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 148.3(c).

Under Texas Labor Code Section 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 Section 413.031.

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