



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

VIA CHRISTIE REGIONAL MEDICAL
C/O LAW OFFICES OF KENNETH K STEPHENS
4315 W LOVERS LN
DALLAS TX 75209

Respondent Name

NETHERLANDS INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-08-5416-01

MFDR Date Received

April 1, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Via Christi would respectfully show that its total charges of \$238,739.95 were fair and reasonable charges in Kansas for the reasonable and necessary care of the patient and claimant . . . The Carrier did pay \$66,099.78 which leaves a remaining balance of \$172,640.17 which is fully supported by the affidavits provided to the Medical Dispute Division. . . . Via Christi Regional Medical Center would respectfully request a decision by the Medical Dispute Division finding that the providers medical charges were fair and reasonable and that the Medical Dispute Division render a decision finding for the full unpaid amount of \$172,640.17 plus statutory interest."

Amount in Dispute: \$172,640.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor asserts it is entitled to reimbursement in the amount of . . . 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges. . . . the per diem rate is the default and preferred method of reimbursement that must be employed unless the hospital justifies use of the stop-loss method . . . There is no evidence submitted by the hospital demonstrating that the services provided by the hospital were unusually extensive. . . . Secondly, there is no evidence that the services provided by the hospital were unusually costly to the hospital. . . . Using the per diem method, this 37 day surgical admission qualifies for \$41,366.00 (\$1,118 * 37 days) in reimbursement. . . . Further, the Requestor is entitled to reimbursement for implantables . . . in a fair and reasonable amount. The carrier would suggest that the hospital's cost plus 10% would be fair and reasonable. . . . The Requestor may also be entitled to additional reimbursement for pharmaceuticals costing in excess of \$250 per dose. The Requestor must document the cost of such pharmaceuticals so Carrier may reimburse at cost plus 10%."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2007 to July 14, 2007	Inpatient Services	\$172,640.17	\$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:
 - W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY. REDUCED TO FAIR AND REASONABLE.
 - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. THE REIMBURSEMENT FOR THIS LINE ITEM HAS BEEN INCLUDED IN THE PAYMENT RECOMMENDATIONS(S) FOR ALL COVERED SERVICES WHICH ARE REPORTED ON ANOTHER LINE OR LINES.
 - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Kansas to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5), which requires that "When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate: (A) Trauma [REDACTED]." Subsection 134.401(c)(6) further states, in pertinent part, that "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." Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as [REDACTED]. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate. Accordingly, the disputed services are exempt from the stop-loss methodology. The applicable rule for determining fair and reasonable reimbursement of the disputed services is 28 Texas Administrative Code §134.1.
3. Former 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."
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. Former 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 position statement asserts that "Via Christi would respectfully show that its total charges of \$238,739.95 were fair and reasonable charges in Kansas for the reasonable and necessary care of the patient and claimant."

- The requestor submitted supporting testimony by affidavit of several expert witnesses. Review of the submitted affidavits finds as follows:
 - A licensed physician and specialist in emergency medicine stated that “the medical charges of Via Christi Hospitals Wichita, Inc. were fair and reasonable . . .”
 - A hospital administration professional familiar with the fair and reasonable charges made by hospitals in Kansas and the Wichita, Kansas area, who had been involved in billing matters for hospitals in the Kansas area for six years stated that “the total charges billed to the insurance company . . . are a fair and reasonable rate in Kansas for the treatment provided . . . The charges for the entire admission were fair and reasonable and were the customary charges charged by hospitals in Kansas and the Wichita, Kansas area.”
 - The same hospital administrator, in his capacity as person in charge of records of Via Christi, stated that “the amounts charged for the services . . . was reasonable at the time and place that the service was provided.”
 - A different hospital administration professional familiar with the fair and reasonable charges made by hospitals in Dallas and the Dallas, Texas area, who had been involved in billing matters for hospitals in the Texas area for fifteen years stated that “the total charges billed to the insurance company . . . are a fair and reasonable rate in Texas for the treatment provided . . . The charges for the entire admission were fair and reasonable and were the customary charges charged by hospitals in Texas and the Dallas, Texas area.”
- 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.
- Despite the testimony presented that the *charges* were fair and reasonable, and that those charges were the customary charges for hospitals in both Kansas and Texas, and the Wichita and Dallas areas, no testimony was found to address whether the amount sought is a fair and reasonable reimbursement for the services in dispute, or was comparable to other reimbursements received for the same or similar services by the same or similar health care providers in the area; or that the requested reimbursement meets the requirements of §134.1(d), or is consistent with the criteria of Labor Code §413.011.
- 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 submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- 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 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.

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 amount sought by the requestor. The requestor has failed to support 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 16, 2014
Date

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.