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

TEXAS ORTHOPEDIC HOSPITAL
c/o HOLLAWAY & GUMBERT
3701 KIRBY DRIVE, SUITE 1288
HOUSTON TX 77098-3926

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box
Number 01

MFDR Tracking Number
M4-08-6251-01

MFDR Date Received
June 16, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As required by law, Texas Orthopedic Hospital billed its usual and customary charges for its services. The total sum billed was $74,241.14…There was no on-site audit performed by the insurance carrier…Per Rule 134.401(c)(6) (A)(i) (iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%... the fees paid by Liberty Mutual Insurance Company do not conform to the reimbursement section of Rule 134.401…In closing, it is the position of Texas Orthopedic Hospital that all charges…are due and payable…under Texas law and the Rules of the Division."

Amount in Dispute: $40,668.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was priced per the providers PPO Agreement with First Health: Billed Charges: $74,541.14; Implant Charges: $49,167.18; Revised Billed Charge Amount: $25,373.96. Because the implants are paid separately, the revised billed charge amount falls below the general Acute Care outlier threshold of $49,615.00; therefore, the bill was priced at the standard per-diem rate minus 10% per the providers own agreement. Implants were reimbursed at cost +10% minus 10% per the provider's PPO contract with First Health. …an adjustment has been made in the amount of 604.56 + interest for the correct amount owed for the implants billed."

Response Submitted by: Liberty Mutual Fire Insurance

Respondent's Post-Appeal Supplemental Response: "Requestor has failed to meet the Austin Third Court of Appeals' mandate that, to qualify for reimbursement under the Stop-Loss Exception…a hospital must demonstrate two things: the services it provided during the admission were unusually costly and unusually extensive, and its total audited charges exceeded $40,000…Requestor bears the burden of proof in this matter…Respondent's review of the record demonstrates no support for unusually extensive services…medical records contained within the Division's medical claim file confirm no surgical complications arose. The operative report specifically notes no intraoperative complications and the post-operative progress notes the Claimant's condition to be stable…The hospital billed a total of $49,167.18 for the implantables. After Liberty's review the

cost of these implantables appears to have been $8,991.46…Respondent appropriately issued payment per the standard Texas surgical per diem rate…"

Response Submitted by: Hanna & Plautt, LLP

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2007 through August 8, 2007	Inpatient Hospital Services	$40,668.53	$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:

Explanation of Benefits

- Z710 –The charge for this procedure exceeds the fee schedule allowance.
- 42- Charges exceed our fee schedule or maximum allowable amount.
- P303– This service was reviewed in accordance with your contract.
- 24- Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- Z711–Tthe charge for this procedure exceeds the customary charges by other providers for this service.
- W10- No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- (PA) – First Health

Findings

1. 28 Texas Administrative Code §134.401(b)(2)(A) titled General Information states, in pertinent part, that "The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:
   (i) a rate for workers' compensation cases pre-negotiated between the carrier and the hospital;
   (ii) the hospital's usual and customary charges; and
   (iii) reimbursement as set out in section (c) of this section for that admission

   In regards to a pre-negotiated rate, the services in dispute were reduced in part with the explanation "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier Liberty Mutual Insurance Co. and Texas Orthopedic Hospital prior to the services being rendered; therefore 28 Texas Administrative Code §134.401(b)(2)(A)(i) does not apply.

   In regards to the hospital's usual and customary charges in this case, review of the medical bill finds that the health care provider's usual and customary charges equal $74,241.14.

   In regards to reimbursement set out in (c), the division determined that this dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5).
2. 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 (ICD-9 codes 800.0-959.50); (B) Burns (ICD-9 codes 940-949.9); and (C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9)." Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 824.8. 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. Former 28 Texas Administrative Code §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. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
6. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
7. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, 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 rationale for increased reimbursement from the *Table of Disputed Services* asserts that "Per DWC Rule 134.401(c)(6), claim pays @ 75% of total charges as charges exceed $40,000.00 stop-loss threshold."
   - The requestor does not discuss or explain how additional payment of $40,668.53 would result in a fair and reasonable reimbursement.
   - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(6).
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The Division has previously found that a reimbursement methodology based upon payment of a 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 the *Acute Care Inpatient Hospital 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."
   - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
   - The requestor does not discuss or explain how 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.

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 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

		7/19/2013
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.