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 Name and Address:		
S TEXAS SPINE & SURGICAL HOSPITAL 18600 N HARDY OAK BLVD SAN ANTONIO TX 78247	MFDR Tracking #:	M4-08-6741-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #:	Date of Injury:	
Indemnity Insurance Company Rep. Box # 15	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "It is our position, based on Texas Administrative Labor Code 413.011, charges billed should "have fair and reasonable reimbursement which is consistent with the criteria of ensures that similar procedures provided in similar circumstances receive similar reimbursement; and 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…." "…We do not feel that the above guidelines were utilized for the services of January 25, 2008 for Gloria Guillen…."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill
3. EOB(s)
4. Comparative EOB(s)
5. Medical Records
6. Pre-authorization Letter
7. Total Amount Sought - $1592.78

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary taken from the Table of Disputed Services: "Submitted for subsequent review to determine if addl pymt is due"

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
1-25-08	W1	Outpatient Surgical Injection	$1592.78	$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 *Use of the Fee Guidelines*, effective January 17, 2008 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code: “W1” (workers compensation state fee schedule adjustment) and “W1” (this line was included in the reconsideration of this previously reviewed bill).

2. 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 January 17, 2008, 33 TexReg 428, 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(e) and (f) 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.”

3. 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. The requestor did not address any proposed methodology that would meet the criteria of Texas Labor Code §413.011(d).

4. Division rule at 28 TAC §133.307©(2)(F)(iii), effective May 25, 2008, 33 TexReg 3954, and applicable to disputes 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”… This request for medical fee dispute resolution was received by the Division on July 17, 2008. The requestor did not submit a position statement that discusses how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307©(2)(F)(iii).

5. Division rule at 28 TAC §133.307©(2)(F)(iv), effective May 25, 2008, 33 TexReg 3954, and applicable to disputes 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”… This request for medical fee dispute resolution was received by the Division on July 17, 2008. Review of the requestor’s 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 completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307©(2)(F)(iv).

6. Division rule at 28 TAC §133.307©(2)(G), effective May 25, 2008, 33 TexReg 3954, and applicable to disputes filed on or after May 25, 2008 requires that the request shall include “documentation that discusses, demonstrates, and justifies that the payment 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. This request for medical fee dispute resolution was received by the Division on July 17, 2008. Review of the requestor’s documentation finds that the requestor has not submitted documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title. Additional payment can not be recommended. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307©(2)(G).

7. The requestor has not stated explicitly what method should be used to determine a fair and reasonable rate of reimbursement. In support of the request for increased reimbursement, the requestor has provided redacted EOBs from other carriers reflecting a higher reimbursement amount for this same or similar procedure. The requestor did not discuss or support how the sample payer(s) determined the payment amount for the similar services or whether such payment was typical for such services, or address how payment at that rate would meet the criteria of Division rule §134.1 or Texas Labor Code §413.011, or otherwise discuss how the evidence supports the request for additional reimbursement. The Division has determined that 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 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."

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 this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307©(2)(F)(iii), §133.307©(2)(F)(iv), or §133.307©(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, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

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:

		2-23-10
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART 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.