TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NORTH TEXAS ER I, LLC.
EXCEL ER WEATHERFORD

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-4806-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we should be reimbursed at 85% of submitted amount."

Amount in Dispute: $17,663.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was paid correctly, no additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 7, 2017	Free Standing Emergency Room Services	$17,663.79	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.1 sets out general provisions regarding medical reimbursement.
3. 28 Texas Administrative Code §134.403 sets out the Hospital Facility Fee Guideline for outpatient services.
4. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.
5. The insurance carrier reduced/denied payment for the disputed services with the following reason codes:
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 619 – THE PROCEDURE/SUPPLY WAS NOT SUFFICIENTLY IDENTIFIED AND/OR QUANTIFIED.
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.

- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. Did the provider request medical fee dispute resolution for any professional services?
2. Does the requesting facility qualify as an "acute care hospital?"
3. Are the insurance carrier's payment reduction reasons supported?
4. What is the applicable rule for determining reimbursement of the disputed services?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The division notes the requestor has submitted a bill for professional services (medical billing form CMS-1500) in addition to a bill for disputed facility services (form UB-04). The service codes listed on the professional bill include CPT codes 99236-25, 93010-59, 73030-LT-26 (with professional services modifier 26), 72040-26 (also with modifier 26), and 12052. Review of the medical fee dispute resolution (MFDR) request finds that the requestor did not list these professional services on the requestor's form DWC060 *Table of Disputed Services*.

   To clarify, codes 73030-LT-TC and 72040-TC *are* listed on the requestor's table but have modifier TC, indicating the technical component performed by the facility. Technical components (modifier TC) provided by the facility are separate services from any professional components (modifier 26) performed by individual physicians. Upon review, the division finds codes 73030-LT-26 and 72040-26 are not listed as disputed on the requestor's table.

   Additionally, code 12052 is listed on the table (without any modifier). This same code is listed on both the facility bill and the professional bill, but without any modifiers in either case to distinguish separate components or services. This charge was paid by the insurance carrier on the EOB for the hospital facility charges. The EOB shows reimbursement for the same payment amount of $561.29 as acknowledged on the requestor's table. The division therefore determines that disputed code 12052 listed on the *Table of Disputed Services* refers to the facility charge (billing form UB-04) and not to the charge on the professional bill (form CMS-1500).

   Rule §133.307(c)(2)(K), requires the MFDR request to include:

   > a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB

   The requestor did not provide any explanations of benefits (EOBs) from the insurance carrier for any of the professional services as billed on form CMS-1500; thus, the insurance carrier's denial or payment for the services cannot be reviewed. Based on the above findings, the division concludes the services listed on the professional medical bill (form CMS-1500) are not part of the request for medical fee dispute resolution.

2. This dispute involves payment for outpatient facility services performed in a free-standing emergency clinic. While Medicare allows payment for such facilities under their Outpatient Prospective Payment System (OPPS), the division has *not* adopted a fee guideline for such facilities.

   The division's *Hospital Facility Fee Guideline—Outpatient*, Rule §134.403(a)(1) specifies this guideline applies to medical services provided in an outpatient acute care hospital. Rule §134.403(b)(1) further defines an "acute care hospital" as a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

Even though the facility billed the services on medical billing form UB-04 (for medical facility services), with Type of Bill code 131 (indicating hospital, outpatient facility *or* free standing clinic—admit through discharge claim), review of records maintained by the Texas Department of State Health Services finds the requesting facility is not licensed as an *acute care hospital* but instead as a "Clinic/Center Emergency Care." Consequently, the division's *Hospital Facility Fee Guideline*s are not applicable to the disputed services.

3. The division notes the insurance carrier reduced payment for the disputed services with reason codes:
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.

   While Rule §134.403 is not applicable to the disputed emergency clinic services, the submitted information does not make clear whether the insurance carrier adopted the reimbursement methodology in the division's *Hospital Facility Fee Guideline--Outpatient* as their rationale for determining the fair and reasonable payment.

   Regardless, the insurance carrier payments do not reflect the appropriate reimbursement as should be calculated if applying that guideline. Therefore, the above carrier payment reduction reasons are not supported.

   Nevertheless, it is the requestor's burden to support the request for additional reimbursement by a preponderance of the evidence. Accordingly, the respondent's reimbursement calculation will not be examined unless the requestor first meets the burden to support the request for additional payment.

4. The division has not established a medical fee guideline for the disputed services. Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), requiring that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

   In the following analysis, the evidence presented by both parties to support or refute each other's positions as to the fair and reasonable payment amount is examined in order to determine which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the services in dispute.

   The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

   28 Texas Administrative Code §134.1(f) requires that:

   > Fair and reasonable reimbursement shall:
   > (1) be consistent with the criteria of Labor Code §413.011;
   > (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   > (3) be based on nationally recognized published studies, published division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

   The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004). Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

   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. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O) requires the requestor to provide:

> 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) or reimbursement rate, as applicable

The division will first review the information presented by the requestor to determine whether it has met the burden to show the payment amount sought is a fair and reasonable rate of reimbursement for the disputed services. If the requestor's evidence is persuasive, then the division will review the evidence presented by the respondent to support that the amount paid was a fair and reasonable reimbursement.

5. Review of the submitted documentation finds that:
   - The requestor asks to be reimbursed "at 85% of submitted amount."
   - The division has found, as stated in the adoption preamble to former *Acute Care Inpatient Hospital Fee Guideline*, "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271).
   - In formulating the fee guidelines, the division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269).
   - While the requesting free-standing emergency room is not a hospital, the above principle is of similar concern. A health care provider's usual and customary charges are not evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services. Payment of the "submitted amount," or a percentage of the billed amount, is not acceptable when reimbursement is left in control of the health care provider.
   - This would ignore the 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.
   - The use of a health care provider's charges (or a percentage of those charges) cannot be favorably considered unless other data or documentation is submitted to support the payment amount sought is a fair and reasonable reimbursement for the services in dispute.
   - No information was presented to support payment "at 85% of submitted amount" would result in a fair and reasonable reimbursement for the disputed services.
   - The requestor did not explain or provided documentation to support how payment "at 85% of submitted amount" ensures quality medical care to injured workers.
   - The requestor did not explain or provided documentation to support how payment "at 85% of submitted amount" achieves effective medical cost control.
   - The requestor did not explain or provided documentation to support how payment "at 85% of submitted amount" ensures similar procedures provided in similar circumstances receive similar reimbursement.
   - The requestor did not explain or provided documentation to support the requested reimbursement is consistent with the criteria of Labor Code §413.011.
   - The requestor did not explain or provided documentation to support that the requested reimbursement satisfies the requirements of Rule §134.1.

   The request for additional reimbursement is not supported. After review of the submitted information, the division concludes the requestor has failed to discuss, demonstrate and justify that the payment amount sought is a fair and reasonable rate of reimbursement for the services in dispute. Consequently, additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

The applicable rule for determining reimbursement of the disputed free-standing emergency clinic services is 28 Texas Administrative Code §134.1, regarding a fair and reasonable reimbursement.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	March 15, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307.

A party seeking review must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M) in accordance with the form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** together with any other information required by 28 Texas Administrative Code §141.1(d).

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