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
VISTA SURGICAL CENTER WEST

Respondent Name
MID-CENTURY INSURANCE CO

MFDR Tracking Number
M4-04-1520-02

Carrier's Austin Representative
Box Number 14

MFDR Date Received
October 2, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier did not make 'fair and reasonable' reimbursement and did not make consistent reimbursement."

Amount in Dispute: $58,212.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached is the completed TWCC-60 form Initial Request for Medical Dispute Resolution. Pursuant to rule 133.307(g), we shall await notification of the appropriate medical dispute resolution action."

Response Submitted by: Wilson, Grosenheider & Jacobs, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 4, 2002	Ambulatory Surgery Center Services	$58,212.05	$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 forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
4. A Medical Dispute Resolution Findings and Decision was originally issued in this dispute on October 10, 2005.
5. The MFDR Findings and Decision was subsequently appealed to the District Court of Travis County, 53rd Judicial District, where an Agreed Order of Remand of Administrative Appeal was entered reversing the above MFDR Findings and Decision and remanding the dispute to the Division for further proceedings.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - M – No MAR
   - N – Not Documented

Issues

1. Did the requestor provide copies of each explanation of benefits relevant to the fee dispute?
2. Did the requestor provide copies of all medical records pertinent to the services in dispute?
3. Did the requestor provide a statement of the disputed issues including the requestor's reasoning for why the disputed fees should be paid?
4. Did the requestor provide a statement of the disputed issues including how the Texas Labor Code and Division rules impact the disputed fee issues?
5. Did the requestor provide a statement of the disputed issues including how the submitted documentation supports the requestor position for each disputed fee issue?
6. What is the rule for determining reimbursement of the disputed ambulatory surgery services?
7. Has the requestor supported that additional reimbursement is due?

Findings

1. Former 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the documentation submitted by the requestor finds that the request does not include a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B).

2. Former 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, pre-operative and post-operative care record, nursing notes, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).

3. Former 28 Texas Administrative Code §133.307(g)(3)(C)(ii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "the requestor's reasoning for why the disputed fees should be paid." Review of the submitted documentation finds insufficient documentation of the requestor's reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(ii).

4. Former 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).

5. Former 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, 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 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 met the requirements of §133.307(g)(3)(C)(iv).

6. This dispute relates to ambulatory surgery center services performed on October 4, 2002 with reimbursement subject to former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   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.

7. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, 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." Review of the submitted documentation finds that:

   - The requestor did not submit a position statement for consideration in this dispute.
   - The requestor's rationale for increased reimbursement from the requestor's *Table of Disputed Services* states: "Carrier did not make 'fair and reasonable' reimbursement and did not make consistent reimbursement."
   - The request for reconsideration states: "Vista Surgical Center West's charges are 'Fair and Reasonable.'"
   - The requestor did not explain how its charges are fair and reasonable.
   - The requestor did not provide documentation to support that its charges are fair and reasonable.
   - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline*, 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" (22 *Texas Register* 6271). 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 an ambulatory surgery center is not a hospital, the above principle is of similar concern in the present case. 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 "in full" is not acceptable when it leaves the ultimate reimbursement in the control of the health care provider—which 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. Therefore, the use of a health care provider's "usual and customary" charges cannot be favorably considered unless other data or documentation is submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - 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 dispute.
   - The requestor did not support that the requested reimbursement would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation 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

In resolving disputes regarding the amount of payment due for health care, the role of the Division is to adjudicate the payment, given the relevant statutory provisions and Division rules. The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent. Even though all the evidence was not discussed, it was considered.

The applicable rule for determining reimbursement of the disputed 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 failed to establish 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 disputed services.

Authorized Signature

	Grayson Richardson	September 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

	Martha Luévano	September 30, 2015
Signature	Medical Fee Dispute Resolution Manager	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 MFDR 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 this *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.