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 MEDICAL CENTER

Respondent Name
TEXAS BUILDERS INSURANCE COMPANY

MFDR Tracking Number
M5-04-3751-02

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 30, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Medical Center Hospital charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum of 70% of billed charges. This is supported by the Focus managed care contract. This managed care contract supports Vista Medical Center Hospital's argument that the usual and customary charges are fair and reasonable and at the very minimum, 70% of the usual and customary charges is fair and reasonable."

Amount in Dispute: $14,798.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Vista Healthcare has unbundled a multitude of items in an effort to maximize their charges to the workers compensation system. . . . Vista Healthcare has not provided any methodology, which they utilized to establish their charges to achieve effective medical cost control in accordance with §413.011(d) of the Texas labor code. . . . Texas Builders Insurance Company applies a consistent payment methodology . . . It is unreasonable to pay more for an outpatient procedure or surgery than an inpatient surgery. . . . Vista Healthcare would have received $1,118.00 for an overnight Acute Care Inpatient Hospital stay. Furthermore, if the inpatient stay had required placement in an intensive care setting, Vista Healthcare would have received $1,560.00 . . . Vista Healthcare would have received a $ 95.96 payment from Medicare for the service performed on July 15, 2003. It makes no sense for an ASC to earn, for approximately one hour of services, over sixteen times the inpatient surgical per diem rate established by TWCC, and over one hundred forty nine times the amount allowed by Medicare."

Response Submitted by: Workers' Compensation Consultants

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2003	Outpatient Surgery	$14,798.20	$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. Former 28 Texas Administrative Code §133.301 sets out procedures for insurance carrier review of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to the use of the fee guidelines.
4. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
5. A Medical Dispute Resolution Findings and Decision was originally issued in this dispute on December 17, 2004.
6. The MDR Findings and Decision was subsequently appealed to the District Court of Travis County, where an Agreed Order of Remand of Administrative Appeal was entered on January 9, 2013, reversing the above MFDR Findings and Decision and remanding the dispute to the Division for further proceedings.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - V – Unnecessary Treatment (with peer review)
   - 169 – Disallowed due to physician advisor review
   - 506 – Re-evaluated bill, payment adjusted
   - 510 – Payment Determined
   - G – Unbundling
   - M – No MAR

Issues

1. Are there any unresolved issues of medical necessity?
2. Did the requestor provide copies of all medical records pertinent to the services in dispute?
3. What is the rule for determining reimbursement of the disputed services?
4. Has the requestor supported that additional reimbursement is due?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - V – Unnecessary Treatment (with peer review)
   - 169 – Disallowed due to physician advisor review

   The requestor's position states, "The Carrier preauthorized the surgery in question. However, in accordance with TWCC Rule 133.301(a), the 'insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title.'" Former Division Rule at 28 Texas Administrative Code §133.301(a), does in fact require that "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization." The requestor has also presented documentation to support that preauthorization was requested and approved for the surgery in dispute. Based on the submitted documentation, the above denial reasons do not meet the requirements of former §133.301(a) and are not supported.

   However, upon reconsideration, the insurance carrier reprocessed the medical bill and issued payment without maintaining the above denial reasons on the reconsideration explanation of benefits. Consequently, the Division concludes that there are no unresolved issues of medical necessity. The medical fee dispute issues will therefore be reviewed per applicable Division rules and fee guidelines.

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, documentation to support administration of the disputed pharmaceuticals and supplies, there are no laboratory or radiology reports 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. This dispute is regarding outpatient hospital services performed on July 15, 2003 with reimbursement subject to the provisions of 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.

   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* 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* 104 (Texas Appeals – Austin 2003, petition for review denied), that "each . . . 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."

4. 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's position statement asserts, "Vista Medical Center Hospital charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services."
   - The requestor did not provide documentation to demonstrate how they determined their usual and customary charges for the services in dispute.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - 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). A health care provider's usual and customary charges are not, alone, evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services. Payment of a health care provider's "usual and customary charges" 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.

- In the alternative, the requestor asks to be reimbursed a minimum of 70% of billed charges, in support of which the requestor states that "The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum of 70% of billed charges. This is supported by the Focus managed care contract. This managed care contract supports Vista Medical Center Hospital's argument that the usual and customary charges are fair and reasonable and at the very minimum, 70% of the usual and customary charges is fair and reasonable."
- The requestor has provided select exhibit pages from the alleged managed care contract referenced above; however, a copy of the contract referenced in the position statement was not presented for review.
- Review of the exhibit pages submitted by the requestor finds a schedule of charges, labeled exhibit "A", dated 04/23/92, which states that "OUTPATIENT SERVICES: 101/401 PAY 70% OF BILLED CHARGES."
- The requestor submitted a letter of clarification dated July 30, 1992 indicating a change in reimbursement to the above referenced contract, stating in part that "services rendered to eligible Beneficiaries will be considered at 80% of the usual and reasonable charge which is equal to the lesser of the actual charges billed by HCP; OR the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research Database."
- The requestor submitted a fee schedule page, labeled exhibit A, dated effective August 1, 1992 which states, in part, that the provider shall receive "an amount equal to eighty percent (80%) of the Usual and Reasonable Charge for those Covered Services. For all purposes hereunder, the Usual and Reasonable Charge for such services shall be equal to the lesser of: (i) the actual charges billed by HCP for such services; or (ii) the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research database."
- No data or information was submitted from the referenced Medical Data Research database to support the requested reimbursement.
- No documentation was presented by the requestor to support that the referenced contract was in effect at the time of the disputed services.
- No documentation was presented to support that the prevailing economic indicators in health care with respect to the services in dispute at the location and time of treatment, eleven years later, were the same or similar to those when the contract was negotiated in 1992.
- The requestor's position statement further states, "amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, TWCC stated specifically that managed care contracts are fulfill the requirements of Texas Labor Code Section 413.011 as they are 'relevant to what fair and reasonable reimbursement is,' they are relevant to achieving cost control,' they are relevant to ensuring access to quality care,' and they are 'highly reliable.' *See* 22 Tex. Reg. 6272. Finally, managed care contracts were determined by the TWCC to be the best indication of a market price voluntarily negotiated for medical services."
- While managed care contracts are relevant to determining a fair and reasonable reimbursement, the Division has also previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 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.

  Therefore, a reimbursement amount calculated based on a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation is submitted to support the fairness and reasonableness of the payment amount sought.

- The requestor did not submit documentation to support that the amount of payment they are seeking 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 additional reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	September 25, 2015
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 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.