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
MEMORIAL HERMANN HOSPITAL SYSTEM

Respondent Name
AMERICAN HOME ASSURANCE CO.

MFDR Tracking Number
M4-09-0119-01

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
March 6, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For the out-patient surgery, the hospital billed its usual and customary charges in the total amount of $21,865.50 reflected in the enclosed UB92 and itemized statement. Because out-patient surgery is carved out of the ACIHG, the hospital's usual and customary charges for operating room, ancillary services and supplies and drug charges should be paid at a fair and reasonable rate. Since the insurance carrier did not conduct an in-house or desk audit on these medical expenses, Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred. The carrier paid a total of $5,103.00 on this surgery. Requestor is owed an additional $16,762.50 on this surgery, plus interest."

Amount in Dispute: $16,762.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consisted with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2007	Outpatient Hospital Services	$16,762.50	$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 §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
   - 226 – INCLUDED IN GLOBAL CHARGE

- 253 – IN ORDER TO REVIEW THIS CHARGES WE WILL NEED A COPY OF THE INVOICE.
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Texas to an injured employee with an existing Texas Workers' Compensation claim. The insurance carrier denied disputed services with reason codes W1 – "WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT," and 790 – "THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE." The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. The insurance carrier responded to the request on September 24, 2008 stating, in part, that "Carrier requests the Division review Requestor's claim under its general obligations to adjudicate disputes in accordance with relevant statutory provisions [including, but not limited to Texas Labor Code §§ 413.011 and 413.031(c)] and commissioner rules [including, but not limited to 28 TAC §§ 134.1, 134.202, 134.302, 134.303, 134.401 and 134.500 series . . . The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable." On or about December 10, 2008, in a telephone call with the Division, a representative of the insurance carrier alleged that the employer is a foreign corporation non-subscriber, that the injured employee is a foreign national, that the injury occurred overseas, and that the injured employee was only sent to Texas for treatment. No documentation was provided to support these allegations. Nevertheless, on February 25, 2013, the Division requested additional information from the respondent pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31 *Texas Register* 10314, which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." The insurance carrier did not respond to the request for additional information; therefore, this decision is based on the information available at the time of review. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, and because the respondent maintains it has paid the disputed health care in accordance to the Texas Medical Fee Guideline and Workers' Compensation State Fee Schedule, and because the respondent has also requested that "the Division review Requestor's claim under its general obligations to adjudicate disputes in accordance with relevant statutory provisions," the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. This dispute relates to outpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 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."
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.
4. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, 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 position statement asserts that "Because out-patient surgery is carved out of the ACIHG, the hospital's usual and customary charges for operating room, ancillary services and supplies and drug charges should be paid at a fair and reasonable rate. Since the insurance carrier did not conduct an in-house or desk audit on these medical expenses, Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred."

- The requestor did not submit documentation to support that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- 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). Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was 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 this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount 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

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. After thorough review and consideration of 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 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 services in dispute.

Authorized Signature

	Grayson Richardson	April 4, 2014
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.