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 and Address

SIERRA PROVIDENCE PHYSICAL
REHAB HOSPITAL
LAW OFFICE OF P MATTHEW ONEIL
6514 MCNEIL DRIVE BLDG 2, SUITE 201
AUSTIN TX 78729

Respondent Name
EL PASO ISD

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-09-8465-01

MFDR Date Received
MAY 21, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As set forth in the attached billing and records, the claimant in this case was admitted and received inpatient rehabilitation hospital procedures, specifically relating to an on-the-job injury resulting in a [redacted] The post-surgery treatment at this facility involved physical rehabilitation therapy, supplies, and pharmaceuticals. Fair and reasonable payment for this claim should be $18,015.93. As such, the Hospital requests that the Division immediately order the Carrier to pay the balance owed and interest due and owed as a result of the underpayment. As required by law, Sierra Providence Physical Rehab Hospital…billed its usual and customary charges for the medical services….As shown by the affidavit evidence attached hereto, 65% of the charges constitutes fair and reasonable payment. This is based on a cost basis and amounts paid by other third party payers."

Amount in Dispute: $11,265.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "our position at this time is that the medical bill for dates of service 7-30-08 thru 8-8-08 from Sierra Providence Rehab were audited correctly and accordingly and that no further allowance is recommended."

Response Submitted by: NovaPro Risk Solutions

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2008 through August 8, 2008	Inpatient Rehabilitation Hospital Services	$11,265.83	$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:
   - W10-No maximum allowable defined by fee guideline. Reimbursement made based on Insurance carrier fair and reasonable reimbursement methodology.
   - 97H-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated. Service(s)/Procedure is included in the value of another service/procedure billed on the same date.
   - 193-Origianl payment decision is being maintained. Upon review, it was determined that the claim was processed properly.

Findings

1. This dispute relates to inpatient rehabilitation services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states 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."
2. 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.
3. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, 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 asserts that additional reimbursement is due "Fair and reasonable payment for this claim should be $18,015.93. As such, the Hospital requests that the Division immediately order the Carrier to pay the balance owed and interest due and owed as a result of the underpayment. As required by law, Sierra Providence Physical Rehab Hospital…billed its usual and customary charges for the medical services….As shown by the affidavit evidence attached hereto, 65% of the charges constitutes fair and reasonable payment. This is based on a cost basis and amounts paid by other third party payers."
   - The requestor did not submit documentation to support that 65% of the charges constitutes fair and reasonable payment.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - 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). 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 Division has 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 that is calculated based upon a percentage of a hospital's billed 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

Signature	Medical Fee Dispute Resolution Officer	01/30/2014 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.