Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Insurance Carrier

Requestor=s Name and Address: Spine Hospital of South Texas 18600 N. Hardy Oak Blvd San Antonio TX 78258	MDR Tracking No.: M4-05-1417-01 Claim No.: Injured Employee's Name:
Respondent's Name and Box #: UNIVERSITY HEALTH SYSTEM Representative Box #01	Date of Injury: Employer's Name: UNIVERSITY HEALTH SYSTEM Insurance Carrier's No.: 73020001068

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC-60 and Position Statement
2. UB-92
3. EOB's
4. Medical records

Position Summary: "…Payment is not in accordance with TWCC Fee Guideline. Used by carrier for charges for which no "MAR" is established. This is only payment exception code utilized by the carrier to deny and/or reduce payment…"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC-60
2. Position statement
3. EOB's

Position Summary: "…Provider has not met it's burden of proof to establish that the amount it seeks complies wit the Act's statutory standards for reimbursement and that Provider's rate of payment does not. Therefore, Provider is not entitled to additional reimbursement…"

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
7/21/04	Hospital Outpatient Services	1, 2, 3	$00.00
TOTAL			$00.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The request for medical dispute in this case was received on 10/25/04.

1. This dispute relates to hospital outpatient services provided in a hospital that are not covered under a Texas Department of Insurance, Division of Workers' Compensation ("TDI, DWC") fee guideline for this date of service. Therefore, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as described in 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d) to achieve, in part, access to quality medical care and effective medical cost control. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

2. The Requestor stated in their position that "…Payment is not in accordance with TWCC Fee Guideline. Used by carrier for charges for which no "MAR" is established. The Respondent made total payments of $5,814.15 with reduction codes of "G - Unbundling" and "F – Reduced according to Fee Guideline" and N – Not documented." Denials of "Unbundling" and "Reduced according to Fee Guideline" are not issues in this dispute as these charges are paid under the fair and reasonable reimbursement for the entire procedure. Documentation submitted by the Requestor substantiates the services as billed.

3. In this situation, the Requestor did not provide sufficient information on what a "fair and reasonable" reimbursement should be for these services. The Requestor purports that their total charges should be considered the amount for the "fair and reasonable" reimbursement. Hospital charges, however, are not a valid indicator of a hospital's costs at providing service nor at what is being paid by other payors. 22 *TexReg* 6269. In addition, Texas Labor Code section 413.011(d) provides, in part: "The [fee] guidelines may not provide for payment at a fee in excess of the fee… **paid** by that individual or by someone acting on that individual's behalf (emphasis added)." The Requestor has provided only charged amounts and not evidence of typical paid amount(s) for the disputed service(s).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

1. 28 Texas Administrative Code Sec. 134.1(d)
2. Other statutes, rules, and reference specified in this decision

PART VII: DIVISION FINDINGS AND DECISION

Based upon the lack of sufficient supporting documentation submitted by the Requestor and in accordance with the provisions of Texas Labor code, Sec. 413.031, the Division has determined that the Requestor **is not** entitled to additional reimbursement.

Decision by:

	James Schneider	10/ 27 /06
Authorized Signature	Typed Name	Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of a medical dispute resolution, findings and decisions are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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