**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:<br><br>Houston Community Hospital<br>PO Box 11586<br>Houston, TX 77293 | MDR Tracking No.: M4-05-4873-01<br>Claim No.:<br>Injured Employee's Name: |
| Respondent's Name and Box #:<br><br>TPCIGA for Paula Insurance Co.<br>Rep Box: 50 | Date of Injury:<br>Employer's Name: Livingston Petroleum Products<br>Insurance Carrier's No.: 098 1736921 88 |

## PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC-60
2. UB-92
3. EOB's
4. Operative Report

Position Summary: "… The Commission has clearly stated that a carrier in a DOP situation cannot establish a "one size fits all" rate of reimbursement. In this case, the carrier has not submitted any case specific analysis or methodology to justify its rate of reimbursement. As such, Houston Community Hospital should be reimbursed at its usual and customary rate…"

## PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC-60
2. UB-92
3. EOB's
4. Position Summary
5.

Position Summary: "…TPCIGA concludes that a fair and reasonable amount of reimbursement for facility charges associated with an outpatient pain management procedure is the lesser of the billed charges or $4,118.00, which is equivalent to a one-day surgical admission. TPCIGA also concludes that a fair and reasonable amount of reimbursement for facility charges associated with an outpatient surgery is the lesser of the billed charges or $2,236.00, which is equivalent to a two-day surgical admission, but which exceeds what Medicare and other payor systems would pay for the same or similar service…"

## PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | CPT Code(s) or Description | Part V Reference | Additional Amount Due (if any) |
|---|---|---|---|
| 06-25-04 | Hospital Outpatient Services | I, II, III | $0.00 |

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

The request for medical dispute in this case was received on March 3, 2005.

I. 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.

II. The Requestor stated in their letter dated, 03-14-05, that they were enclosing copies of EOB's from other carrier's, which show a higher rate of reimbursement that is consistent to their usual and customary. However, the Requestor did not submit any EOB's with their dispute.

III. 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:**

| | Patricia Rodriguez | 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.**