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: Vista Hospital of Dallas 4301 Vista Rd Pasadena, TX 77504	MDR Tracking No.: M4-05-8770-01 Claim No.: Injured Employee's Name:
Respondent's Name and Box #: Texas Mutual Ins. Co. Rep Box: 54	Date of Injury: Employer's Name: Pappys Sand & Gravel, Inc. Insurance Carrier's No.: 99D0000353019

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC 60
2. UB-92
3. EOB's
4. Medical Records

Position Summary from the Table of Disputed Services: "…Carrier did not adhere to 133.304 and did not provide final action in timely manner. F-217 Code used incorrectly for charges for which not "MAR" has been established. Carrier has not provided the proper payment exception in this instance, which is in violation of the Texas Administrative Code. Unbundling rule does not apply to Out Patient Services.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC-60 Response
2. ASC Payment Group List

Position Summary: "…It is this carrier's position that a) the requester failed to produce credible evidence that its billing for the disputed procedures is fair and reasonable; b) the requester failed to prove its usual and customary fees for the service in dispute is fair and reasonable are consistent with Section 413.011(b); c) this carrier's payment is consistent with fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code; and d) Medicare fair and reasonable reimbursement for similar or same services is below this carrier's."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
06-24-04	Hospital Outpatient Services	1-3	$0.00

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

The request for medical dispute in this case was received on 05-24-05.

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 states in their position statement that the Respondent used an inappropriate payment exception code F-217 ("F-Reimbursed to fair and reasonable" and "217-The value of this procedure is included in the value of another procedure performed on this date"). If the Responded used inappropriate exception codes a referral will be made to Legal and Compliance and the decision remains the same. Denials of "Unbundling" and "Reduced according to Fee Guideline" are not issues in this dispute as these charges are paid under fair and reasonable reimbursement for the entire procedure.

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:

	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.