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 4301Vista Rd Pasadena, TX 77504	MDR Tracking No.: M4-05-8923-01 Claim No.: Injured Employee's Name:
Respondent's Name and Box #: Insurance Co of the State of PA Rep Box: 19	Date of Injury: Employer's Name: Sodexho, Inc. Insurance Carrier's No.: 023050000257500001

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

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

Position Summary: "…the Carrier did not reference the incorrect application of code "F" to fee codes in the intial MDR response; ….the Carrier's denial based upon insufficient documentation is inappropriate under the Texas Administrative Code; …The amount of reimbursement deemed to be fair and reasonable by Vista Healthcare is at a minimum of 70% of billed charges. This is supported by a managed care contract with "Focus"."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

1. DWC-60 Response

Position Summary: "…The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that $7,456.03 represents an amount greater than or equal to the fair and reasonable reimbursement for this service. The provider must prove that the reimbursement received is not fair and reasonable; … Because the Requestor has failed to prove that the reimbursement received is not fair and reasonable, Requestor is not entitled to further 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)
07-01-04	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 that the Respondent used inappropriate exception codes to reduce payment of their bills. If the Respondent did not use the appropriate exception codes a referral will be made to Legal and Compliance and the decision remains the same. The Requestor also states that they should be reimbursed 70% of charges based upon a contract with Focus. No copy of the Focus contract was submitted with this dispute and therefore will not be considered in this review.

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	10-27-03
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.