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

PLAZA SPECIALTY HOSPITAL
C/O LAW OFFICE OF P. MATTHEW O'NEIL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729-7720

Respondent Name
HIGHLANDS CASUALTY COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-10-0066-01

MFDR Date Received
August 18, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier did initially authorize 7days beginning 8/18/08 to 8/25/08. However, the Carrier denied two of those days only because the patient was not admitted until 8/20/08/. Thus, the Carrier apparently only agreed to pay for dates of service of 8/20 to 8/25/08, although seven days were authorized. . . . when it was clear that the patient's wound treatment required additional medical treatment beyond 8/25/08, the Hospital contacted Dana with Highlands, who represented that the additional days were authorized."

Amount in Dispute: $38,347.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "for this hospitalization, the hospital only obtained preauthorization for five of the days that the claimant was hospitalized. . . . Therefore, the carrier is not liable for services rendered in this hospitalization from the dates 08/25/08 to 09/26/08."

Response Submitted by: Beverly L. Vaughn, Attorney-At-Law, 5501-A Balcones Drive, #104, Austin, Texas 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2008 to September 26, 2008	Inpatient Hospital Services	$38,347.38	$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. 28 Texas Administrative Code §134.404 sets out the fee guidelines for acute care inpatient hospital services.
4. 28 Texas Administrative Code §134.600 sets out the guidelines regarding preauthorization of services.

5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 57 – Payment based upon DRG 920 and is inclusive of MEDSURGYPVT, ROOMBOARD SEMI, PHARMACY, PHARMDRUG INCID RAD, PHARMIV SOLUTIONS, MEDUR SUPPLIES, STERILE SUPPLY, LAB OR LABORATORY, CT SCAN, PHYSICAL THERP, PHYS THERPEVAL, OCCUPAT-IONAL THER, OCCUP THERPEVAL, DRUGS DETAIL CODE, TREATMENT RM
   - 39 – Preauthorization was not granted for DOS 8-26-2008 to 9-26-2008. All services rendered on these DOS are denied for lack of preauthorization.
   - 97 – unbundling of institutional services
   - 91 – Payment is included in the allowance for another service or procedure for this inpatient hospital admission.

Issues

1. Were the disputed services preauthorized?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code 39 – "Preauthorization was not granted for DOS 8-26-2008 to 9-26-2008. All services rendered on these DOS are denied for lack of preauthorization." Per 28 Texas Administrative Code §134.600(c), effective May 2, 2006, 31 *Texas Register* 3566, states, in pertinent part, that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care." §134.600(p) states that "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; " §134.600(q) states that "The health care requiring concurrent review for an extension for previously approved services includes: (1) inpatient length of stay." No documentation was found to support a medical emergency. Review of the submitted documentation finds that the health care provider did obtain preauthorization for disputed dates of service August 20 through August 25, 2008. No documentation was found to support that the health care provider sought concurrent review or obtained an extension for previously approved services including the length of stay. The requestor asserts that "when it became clear that the patient's wound treatment required additional medical treatment beyond 8/25/08, the Hospital contacted Dana with Highlands, who represented that the additional days were authorized." The respondent contends that "The person referred to as 'Dana' in the hospital's position statement is a nurse case manager who works for Integrated Care Management. She does not have authority to preauthorize healthcare. And, neither Highlands Insurance Company nor Coventry, the agent for preauthorization, preauthorized the health care rendered from 08/25/08 to 09/26/08." Per §134.600(f) "Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission." Per §134.600(j) "The carrier shall send written notification of the approval or denial of the request within one working day of the decision…" No documentation was submitted to support that a request for concurrent review had been sent to the insurance carrier. No documentation was presented to support that the insurance carrier had approved the request for concurrent review. No documentation was found to support that the hospital obtained approval for an extension of the length of stay prior to providing the disputed services. The insurance carrier's denial reason is supported. Reimbursement for dates of service August 26 to September 26, 2008 is not recommended.
2. Although the disputed services are inpatient hospital services, the services are not acute care, but rather long-term care services. Per Texas Administrative Code §134.404(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register." Medicare does not assign a value to the long-term care services in dispute under the IPPS. Rather, Medicare has a separate payment system, the Long-Term Care Hospital Prospective Payment System, for determining reimbursement of the services in dispute; therefore, an amount cannot be determined by application of the formula to calculate the MAR as outlined in §134.404(f).

Per §134.404(e)(3), "If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement)."

Review of the submitted information finds that no contracted fee schedule exists and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection 134.404(f); therefore, reimbursement shall be determined in accordance with 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."

Additionally, 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 position statement asserts that "the DRG was 920 with a DRG weight of .8518. Medicare and federal payment and reimbursement in the amount of $33,332.74 are based on this DRG, not the length of stay. . . . 143% of the Medicare allowable should have been paid, or $47,665.82"
   - As stated above, the Division's rule at 28 Texas Administrative Code §134.404(f) is not applicable to the services in dispute, as Medicare does not assign a value to the long-term care services in dispute under the Inpatient Prospective Payment System.
   - Review of the submitted documentation finds that the requestor calculated the reimbursement amount sought by multiplying the Division's inpatient acute care payment adjustment factor of 143%, as found in 28 Texas Administrative Code §134.404(f)(1), by the payment amount calculated under Medicare's Long-Term Care Hospital Prospective Payment System; however, §134.404(f) requires that reimbursement be determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula—not the Long-Term Care Prospective Payment System formula.
   - As stated in the adoption preamble to §134.404, 33 *Texas Register* 405 (January 11, 2008), "In adopting PAFs for use in §134.403 and §134.404, the Division has conducted extensive research to understand hospital reimbursement in the current Texas workers' compensation system, including: reimbursement rates, the reimbursement rates as compared to Medicare reimbursement, and the reimbursement rates as compared to non-workers' compensation reimbursement for hospital services. . . . The Division has also considered economic indicators for hospitals that are particularly relevant to the analysis process. Hospital Medicare margins and hospital market basket information reflect the general increasing costs of hospital care over time. . . . The Division, however, must consider additional factors in setting the PAFs. The ratio of Medicare reimbursement to reimbursement made by other payors is an important and necessary comparison in order to comply with §413.011. In adopting a PAF, the Division has noted and considered the recommendations made by system stakeholders. . . . These rates were paired with various adjustments to the overall Medicare reimbursement methodology. Additionally, the Division has considered information provided by Ingenix relating to the market share of inpatient and outpatient services for Medicare, HMO, PPO, POS, and commercial indemnity payor groups and the reimbursement rates of those payors when indexed to Medicare payments. This set of reimbursement rate recommendations and observations provides a general range of rates that is reflective of the current hospital market to consider in adopting a PAF."
   - No documentation was presented to support that the Division's payment adjustment factor for inpatient acute care services of 143%, as found in 28 Texas Administrative Code §134.404(f)(1), would provide for a fair and reasonable reimbursement when applied to the payment amount calculated under Medicare's Long-Term Care Hospital Prospective Payment System; therefore, the use of such methodology 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 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	[redacted] Medical Fee Dispute Resolution Officer	February 14, 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.