Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SHANNON MEDICAL CENTER
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Carrier's Austin Representative Box
Box Number 44

Respondent Name
OLD REPUBLIC GENERAL INSURANCE CO

MFDR Date Received
March 30, 2012

MFDR Tracking Number
M4-12-2487-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Shannon Medical Center to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine to be the correct amount for this inpatient surgery per the Texas fee schedule in effect as of 2008. Per the applicable Texas fee schedule the correct allowable would be per the DRG 482 The allowable for this DRG per Medicare is $8,688.93, we have also attached the print out for your review from the Medicare pricer program. The correct allowable would be at 108% as implants were carved out, making the allowable at $9,384.04. Also per the invoices submitted the payment for the implants should have been $5,795.68 making the allowable at $15,179.72. Based on their payment of $12,222.41, there is an additional of $2,957.31, still due at this time."

Amount in Dispute: $2,957.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated April 5, 2012: "We have escalated this request to our managed care vendor to verify the claim has been processed according to the Texas State Fee Schedule. Once the bill has finished processing. We will submit our findings."

Respondent's Amended Position Summary dated April 19, 2012: "After our State dispute department carefully reviewed the complaint. Their response is as follows: 'Until the provider sends in the proper documentation for the implants, we cannot review them and adjust them for payment.' When the provider submits the claim with all proper documentation including the implant invoices we will have the bill reviewed at that time."

Response Submitted by: Gallagher Bassett Services, Inc., 6404 International Parkway #2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2011 To July 10, 2011	Inpatient Hospital Surgical Services	$2,957.31	$124.25

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (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).
4. 28 Texas Administrative Code §134.404(f) states that "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. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. 28 Texas Administrative Code §134.404(g) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 18, 2011
   - 16 — (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.

   Explanation of benefits dated November 24, 2011
   - 1 — The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - 2 — Payment for this charge is not recommended without documentation of cost. (X023)

   Explanation of benefits undated
   - 18 — (18) DUPLICATE CLAIM/SERVICE.

   Explanation of benefits dated undated
   - 18 — (18) DUPLICATE CLAIM/SERVICE.
   - BL — THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.
   - BL — ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS CLAIM WAS PAID IN ACCORDANCE WITH STATE GUIDELINES, USUAL/CUSTOMARY POLICIES, OR THE PROVIDER
   - 18 — (18) DUPLICATE CLAIM/SERVICE.
   - 18 — (18) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THE PREVIOUSLY REVIEWED BILL.

Issues

1. Did the respondent support denial reason code '16'?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The respondent denied reimbursement for the disputed services based upon claim/service lacks information needed for adjudication. 28 TAC §133.3 requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the respondent to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." Review of the explanation of benefits dated November 24, 2011 the respondent denied reimbursement based on "Payment of this charge is not recommended without documentation of cost." The Division finds documentation to support communication of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. For this reason, the Division finds that the 16 claim adjustment code is supported.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds that, although the provider requested separate reimbursement for the implantables, the provider did not provide copies of invoices or other documentation to support the manufacturer's invoice amount or the net amount (exclusive or rebates and discounts) for the disputed implantables. The provider did not meet the requirements of §134.404(g). The Division, therefore, concludes that the provider did not request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g).
4. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 482 is $8,634.03. This amount multiplied by 143% is $12,346.66. The total maximum allowable reimbursement (MAR) is therefore $12,346.66. The respondent previously paid $12,222.41, therefore an additional amount of $124.25 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $124.25.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $124.25 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 13, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN 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.