TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PINE CREEK MEDICAL CTR

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-12-2669-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 16, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In this case the MAR was not applied correctly, which resulted in the claim being underpaid."

Amount in Dispute: $1,978.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier relies upon its review and reduction of the provider's bill as reflected in its EOBs. The carrier asserts that it has paid according to applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2011 to October 20, 2011	Inpatient Hospital Services	$1,978.04	$1,978.04

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 §134.404 sets out the acute care hospital fee guideline for inpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 169 – REIMBURSEMENT BASED ON RATIO, PERCENTAGE OR FORMULA SET BY STATE GUIDELINES.
   - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CO – The amount adjusted due to a contractual obligation between the provider and the payer. It is not the patient s responsibility under any circumstances.
   - OA – The amount adjusted is due to bundling or unbundling of services.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME

Issues

1. Are the disputed services subject to a contracted fee arrangement or contractual obligation?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT."; and CO – "The amount adjusted due to a contractual obligation between the provider and the payer. It is not the patient s responsibility under any circumstances." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The submitted documentation does not include a copy of the alleged contract that the respondent seeks to apply. No documentation was found to support that the insurance carrier is a party to the alleged contract. No documentation was found to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the time period that the disputed services were rendered. No documentation was found to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time the disputed services were rendered. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states that:

   > The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] 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.

   Review of the submitted documentation finds that separate reimbursement for implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B).

3. Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 473. The services were provided at Pine Creek Medical Center, Dallas, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $11,463.14. This amount multiplied by 108% results in a MAR of $12,380.19.

   Per §134.404(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.404(g). The facility's total billed charges for the separately reimbursed implantable items below are $36,955.00. Accordingly, the facility's total billed charges have been reduced by this amount when calculating any outlier payments.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g):

   > 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.

   Review of the submitted documentation finds that the separate implantables include:

   - "IMP DISTRACTION PIN 14MM" as identified in the itemized statement and labeled on the invoice as "14 mm Distraction Pin SS Sterile - 10 Single Packs" with a cost per unit of $30.00;
   - "IMP OSTEO DBM PUTTY 1CC" as identified in the itemized statement and labeled on the invoice as "1cc GRAFTON DBM PUTTY" with a cost per unit of $216.00;
   - "IMP CPM PLT 32MM 2-LVL CERV" as identified in the itemized statement and labeled on the invoice as "Cervical Plate Two Level 32mm" with a cost per unit of $1,100.00;
   - "IMP CPM SCR 4 X 12MM SD" as identified in the itemized statement and labeled on the invoice as "Screw Self-Drilling 4.0x12mm" with a cost per unit of $225.00 at 6 units, for a total cost of $1,350.00;
   - "IMP UNI-INSTR PRP BONE MARROW" as identified in the itemized statement and labeled on the invoice as "Bone Marrow Aspirate Kit" with a cost per unit of $1,500.00;
   - "IMP UNI-INSTR CAGE 5MM CERV" as identified in the itemized statement and labeled on the invoice as "AMT, SHELL Cage, cervical 5mm x 14 mm" with a cost per unit of $1,100.00 at 2 units, for a total cost of $2,200.00;
   - "IMP UNV-INSTR AMNIOFIX 2X3CM" as identified in the itemized statement and labeled on the invoice as "AmnioFix Amniotic Membrane Allograft - Spine 2X3 cm" with a cost per unit of $995.00.

   The total net invoice amount (exclusive of rebates and discounts) is $7,391.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $739.10. The total recommended reimbursement amount for the implantable items is $8,130.10.

5. The total allowable reimbursement for the services in dispute is $20,510.29. The amount previously paid by the insurance carrier is $18,199.44. The requestor is seeking additional reimbursement of $1,978.04. This amount is recommended.

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 $1,978.04.

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 $1,978.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	October 16, 2015
Signature	Medical Fee Dispute Resolution Officer	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 MFDR 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 this *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.