



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name

VICTORY MEDICAL CENTER HOUSTON

Respondent Name

HARTFORD INSURANCE COMPANY

MFDR Tracking Number

M4-12-3466-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

July 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was denied for not having a Medicare Provider Number... There is no Medicare Provider Number on file or on the claim even though we have sent in a letter of explanation for not have a Medicare Provider Number. The inclusion of a Medicare Provider Number IS NOT a required element for claim consideration and reimbursement. Also, according to TAC -28, Chapter 134.404. Victory Medical Center Houston meets the definition of an "Acute Care Hospital" and reimbursement as a Worker's Compensation provider... It is our opinion that our total reimbursement for both the services and the implants should be \$59,526.71."

Amount in Dispute: \$59,526.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Hartford has requested on several occasions a valid Medicare number in order to price billing correctly. To date, we do not show a record of receipt of this information."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. It lists medical services like DRG 460, TLIF VBR, and Polyaxial Screws with their respective amounts.

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 Inpatient Hospital Facility Fee Guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16 – Claim/service lacks information, which is needed for adjudication, Medicare number is not found on TX provider file.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Did the Requestor submit sufficient documentation to meet the requirements outlined in 28 Texas Administrative Code §134.1?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for inpatient hospital services rendered from September 1, 2011 through September 3, 2011 and November 21, 2011 through November 23, 2011. The Requestor billed the Respondent \$194,053.25, received payment from the Respondent in the amount of \$0.00, and is requesting an additional payment in the amount of \$59,526.71. The Requestor seeks reimbursement under 28 Texas Administrative Code §134.404. The Requestor acknowledges that the hospital does not have a Medicare Provider Number and requests reimbursement under 28 Texas Administrative Code §134.404.”

Per 28 Texas Administrative Code §134.404 (f)(1), “(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*. 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.”

The Division finds that the provisions of Per 28 Texas Administrative Code §134.404 (f) (1) do not apply, as the facility does not have a “Medicare facility specific amount.” As a result, this dispute relates to inpatient hospital services with reimbursement subject to 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626. 28 Texas Administrative Code §134.1 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.”

Former 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.

2. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “...documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.”

28 Texas Administrative Code 134.1(f) (2) requires that “fair and reasonable reimbursement” shall “...ensure that similar procedures provided in similar circumstances receive similar reimbursement...” Review of the submitted documentation finds that:

- In support of the requested reimbursement methodology, the requestor states in pertinent part, “Using the CMS pricer for 10/01/10-09/30/11, the Medicare DRG 460 allowable for the Houston area is \$21,321.03. One hundred and eight percent of \$21,321.03 is \$23,026.71...”
- The requestor did not submit documentation to support the Medicare payment calculation for the services in dispute.
- The Division disagrees that the fee guidelines as set forth in §134.404 are “presumptively fair and reasonable reimbursement under the law.” No documentation was found to support such a presumption under law.

- While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284), Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d) ... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."
 - The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in 28 Texas Administrative Code §134.404, effective for dates of service on or after March 1, 2008, would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.
 - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the alternative requested reimbursement.
 - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.
3. The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1(f) (2). 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

For the reasons stated above, the Division finds that 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

		February 5, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

		February 5, 2016
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request 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 §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.