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

PLAINS MEMORIAL HOSPITAL
310 WEST HALSELL
DIMMITT TX 79027

Respondent Name

TEXAS MUNICIPAL LEAGUE
INTERGOVERNMENTAL RISK

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

NOVEMBER 13, 2013

MFDR Tracking Number

M4-14-0836-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Request for reconsideration. We get paid by Medicare Guidelines and are a Critical Access Hospital and denied charges Should have been paid. The Professional charges should also get paid on a UB-04. I did file and appeal and charges were still denied. I have attached our CMS rate Letter, our Critical Access Letter, and Medical Records."

Amount in Dispute: $1,723.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Memo from Texas Municipal League IRP: "The provider is requesting 100% reimbursement on charges disallowed stating that they are a Critical Access Hospital and the Acute Care Outpatient Fee Schedule does not apply. Note that the reimbursement allowed by the Carrier is not being disputed only those charges not allowed. Upon review, it does appear that Plains Memorial Hospital is classified by Medicare as a Critical Access Hospital (CAH) according to CMS NPI Registry. According to CMS policy, there are 2 methods of reimbursement for CAS services…The provider submitted a letter indicating a cost per day of $2167.79 and an outpatient rate of 63% which would equate to $1365.71 for outpatient services per day. (63% of $2167.79 is $1365.71). Since there is no contractual agreement between the provider and TMLIRP nor is there an applicable fee guideline then reimbursement is based on a Fair and Reasonable reimbursement per DWC Rule 134.1(f). TMLIRP's reimbursement of $1405.08 exceeds the above allowable amount of $1365.71. TMLIPR utilized the Medicare OPPS/APC Rates X 200% to determine a Fair & Reasonable reimbursement rate."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2013	Hospital Outpatient Services	$1,723.00	$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, 37 *Texas Register* 3833, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, reimbursement guidelines for medical services provided in an outpatient acute care hospital on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1 effective March 1, 2008, 33 *Texas Register* 626, sets forth general provisions related to medical reimbursement.
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:

   Explanation of benefits

   - 97-Payment is included in the allowance for another service/procedure.
   - W1-Workers compensation state fee schedule adjustment.
   - 414, 171-Professional services must be billed on CMS1500 claim form. Payment is denied when performed/billed by this type of provider in this type of facility.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Is the requestor classified as a Critical Access Hospital (CAH)?
2. What is Medicare's reimbursement policy for CAH?
3. What is the DWC reimbursement methodology applicable to this dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. According to CMS, a hospital must meet one of the following criteria to be classified/reclassified as a Critical Access Hospital (CAH):
   • the hospital is located in a non-MSA county; or
   • the hospital is located in a census tract considered rural under the Goldsmith Modification; or
   • the hospital is treated as rural by the State through a statutory or regulatory provision adopted by the State.

   According to CMS NPI Registry, Plains Memorial Hospital in Dimmitt, TX is classified as a CAH.

2. Pursuant to 28 Texas Administrative Code §134.403(d), "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date of service is provided with any additions or exceptions specific in this section."

   According to CMS policy, there are two methods of reimbursement for CAH services:

   - The Standard Payment Method – CAH facility services are paid at 101 percent of reasonable costs.
   - The Optional Payment Method – CAH facility services are paid a reasonable cost-based facility service plus 115 percent fee schedule payment for professional services.

   According to CMS policy, CAHs elect from the two payment methodologies: Standard or Optional.

3. Pursuant to 28 Texas Administrative Code §134.403(d), "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date of service is provided with any additions or exceptions specific in this section."

   Pursuant to 28 Texas Administrative Code §134.403(e)(1-3), "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), 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)."

The submitted documentation does not support that a contractual agreement for the disputed services exists; therefore, 28 Texas Administrative Code §134.403(e)(1) does not apply.

28 Texas Administrative Code §134.403(f), "The reimbursement calculation used for established the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*."

According to CMS policy, CAHs are not subject to the Hospital Outpatient Prospective Payment System; therefore, 28 Texas Administrative Code §134.403(e)(2) does not apply.

In accordance with 28 Texas Administrative Code §134.403(e)(3) reimbursement for the disputed services shall be determined in accordance with 28 Texas Administrative Code §134.1.

4. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, 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."

   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.

   28 Texas Administrative Code §133.307(c)(2)(o) requires the provider to submit with the request for dispute resolution, "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." Review of the submitted documentation finds that:

   - The requestor's position statement asserts that "We get paid by Medicare Guidelines and are a Critical Access Hospital and denied charges Should have been paid. The Professional charges should also get paid on a UB-04. I did file and appeal and charges were still denied."
   - The requestor did not submit documentation to support that additional payment of $1,723.00 is fair and reasonable reimbursement.
   - The requestor does not discuss or explain how $1,723.00 supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - 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

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 $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 disputed services.

Authorized Signature

		01/17/2014
Signature	Medical Fee Dispute Resolution Officer	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, effective May 31, 2012, *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 MDR 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.