



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

CHG Hospital of Bellaire

Respondent Name

Insurance Co of the State of PA

MFDR Tracking Number

M4-15-1264-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$43,504.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor billed \$132,004.09 for these dates of service and shows on the DWC 060 that the carrier paid \$10,853.05. The Carrier payment shown on the DWC 060 is not correct. I have attached the Explanation of Bill Review showing the carrier paid \$19,770.01 for these dates of service. The Explanation of Bill Review explains the Carrier's payment and we ask that your find that Cornerstone Hospital has been paid the correct amount per the DWC Medical Fee Guidelines."

Response Submitted by: AIG, 4100 Alpha Rd, Ste 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2014 to June 24, 2014	Long Term Care Hospital Services	\$43,504.69	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.1 sets out general provisions related to medical reimbursement.
- 28 Texas Administrative Code §134.404 sets out the fee guidelines for inpatient hospital services.
- Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment

- P300 – The amount paid reflects a fee schedule reduction
- Z710 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Can an amount determined by application of the formula to calculated the MAR as outlined in §134.404
2. What is the applicable rule for determining reimbursement?
3. Did the requestor submit a position statement that meets the requirements of §133.307 (c)(2)(F)?
4. Did the requestor support that the amount being sought is a fair and reasonable rate of reimbursement?

Findings

1. Although the disputed services are inpatient hospital services, the services in dispute 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 calculated the MAR as outlined in §134.404(f).
2. Per §134.404(e)(3), “If not 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).” No contracted fee schedule exists and an amount cannot be determined by application of the formula to calculated the MAR as outlined in subsection (f); therefore, reimbursement shall be determined in accordance with 28 Texas Administrative Code §134.1.

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 works’ 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 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 on 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. 28 Texas Administrative Code §133.307(c)(2)(N) requires, “a position statement of the disputed issue(s) that shall include: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue;” Review of the submitted documentation finds the requestor has not met the requirements of §133.307(c)(2)(N).
4. 28 Texas Administrative Code §133.307(c)(2)(O) requires requests to include, “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 has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- 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 of 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, and the thorough review and consideration of that evidence. After thorough review and consideration of all 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. 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

		June , 2015
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, 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.