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 CENTER

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-16-3624-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center was paid $2,852.52 for the implant however, the claim remains under paid. There was not payment for the procedure DRG 488."

Amount in Dispute: $13,128.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the Medical Dispute, the bills were sent for reconsideration. It has been determined that no additional payment is due to the provider."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2015	Inpatient Hospital Services	$13,128.36	$10,935.19

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

1. 28 Texas Administrative Code §133.305 sets out general provisions regarding medical dispute resolution.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
4. 28 Texas Administrative Code §133.3 sets rules for communication between providers and insurance carriers.
5. 28 Texas Administrative Code §133.210 sets out documentation requirements.
6. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 188 – Please submit a copy of the report and the bill for our review
   - 131 – Claim specific negotiated discount. (ANSI131)
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. (ANSI16)
   - ES100 – Charges for surgical implants are reviewed separately by ForeSIGHT Medical. Please direct inquiries regarding surgical implant charges to ForeSIGHT Medical at 813-930-5346.
   - ETBR – A technical Bill Review (TBR) has been performed.
   - FIR – Further Information Required

Issues

1. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Was there a claim specific negotiated discount?
3. Does the claim lack information which is needed for adjudication?
4. Must inquiries regarding surgical implant charges be directed to the insurance carrier's agent delegated separate responsibility for reviewing such charges?
5. What is the applicable rule for determining reimbursement for the disputed services?
6. What is the recommended payment amount for the services in dispute?
7. What is the additional recommended payment for the implantable items in dispute?
8. Is the requestor entitled to additional reimbursement?

Findings

1. §133.307(d)(2)(F) states that " The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent submitted a copy of an internal "Review Analysis" containing several new claim adjustment codes and denial reasons. The additional claim adjustment codes and denial messages do not match the explanation of benefits submitted by the requestor (as enumerated in the Background section above). The respondent did not submit information to MFDR sufficient to support that the submitted review analysis had ever been presented to the requestor or that the requestor had otherwise been informed of these new denial reasons or defenses prior to the date that the request for medical dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review.

2. The insurance carrier denied disputed services with claim adjustment reason code 131 – "Claim specific negotiated discount. (ANSI131)."

   28 Texas Administrative Code §134.404(e) states that, 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 mounts and reimbursement for implantables.

   The respondent did not present any documentation to support a claim specific negotiated discount or a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011.

   The insurance carrier's denial reason is not supported. Consequently, reimbursement will be reviewed pursuant to Rule §134.404(e)(2) which requires that the MAR be determined in accordance with subsection (f).

3. The insurance carrier denied disputed services with claim adjustment reason code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. (ANSI16)"; and FIR – "Further Information Required."

   28 Texas Administrative Code §133.3(a) 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 responder 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 submitted communication from the insurance carrier to the health care provider regarding the medical bill processing finds that this denial explanation was not 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. Documentation was not provided to support that the health care provider had otherwise been informed of the information requested to aid the insurance carrier in their bill review.

   Furthermore, Rule §133.3(b) requires that "Communication between the health care provider and insurance carrier related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery."

   The respondent did not submit documentation to support that any attempts had been made to notify the health care provider by telephone or electronic transmission of the additional information needed for adjudication of the medical bill. No documentation was submitted to support that the information could not be requested by those media.

   For the above reasons the Division finds that the insurance carrier has not met the communication requirements of Rule §133.3. These denial reasons are not supported.

   Review of the submitted medical documentation finds that the submitted information is sufficient to support the services as billed. The medical fee issues will therefore be reviewed according to applicable division rules and fee guidelines.

4. The insurance carrier reduced payment for the surgically implanted items with reason code ES100 – "Charges for surgical implants are reviewed separately by ForeSIGHT Medical. Please direct inquiries regarding surgical implant charges to ForeSIGHT Medical at 813-930-5346."

   28 Texas Administrative Code §133.210(e) states that "It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other."

   28 Texas Administrative Code §133.307(d)(2)(B) requires the respondent to provide:

   > a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request;

   28 Texas Administrative Code §133.307(d)(2)(D) further requires the respondent to provide:

   > a copy of any pertinent medical records or other documents relevant to the fee dispute not already provided by the requestor;

   28 Texas Administrative Code §133.305(a)(9) defines the respondent in a medical fee dispute as "The party against whom relief is sought." The insurance carrier is ultimately the responsible party against whom relief is sought in a request for medical fee dispute resolution. It is the insurance carrier's obligation to provide to the Division's Medical Fee Dispute Resolution section any pertinent records or documentation to support its medical bill payments and reductions during a requested review of the medical fee issues.

Moreover, it is the insurance carrier's obligation to furnish its agents with a copy of the request for medical fee dispute resolution and any other information necessary for the resolution of the medical fee issues in dispute. Pursuant to rule §133.210(e) the Division considers a request for medical fee dispute resolution possessed by one entity to be simultaneously possessed by the other(s).

Review of the submitted information finds that the respondent did not present information to explain or support its reduction of payment for the surgical implant items. The medical fee issues will therefore be reviewed per applicable division rules and fee guidelines.

5. This dispute regards the facility medical services of an inpatient acute care hospital with reimbursement subject to the provisions of 28 Texas Administrative Code §134.404(f), which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule.

   Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.404(f)(1)(B), the facility specific reimbursement amount, including any outlier payment, shall be multiplied by 108 percent.

   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 billed charges for the separately reimbursed implantable items equal $15,400.00. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating outlier payments.

6. Review of the submitted information finds that the disputed services are supported as billed. Payment is recommended pursuant to Rule §134.404(f)(1)(B). Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. The DRG code assigned to the services in dispute is 488. The services were provided at Pine Creek Medical Center in Dallas, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $9,643.62. This amount multiplied by 108% results in a MAR of $10,415.11.

7. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g), when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B), implantables are 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 the following implantables:

   - "IMP U2 TIBIAL INSRT 5X11MM" as identified in the itemized statement and labeled on the invoice as "XPE Tibial Insert PS #5, 11mm" with a cost per unit of $2,535.00;
   - "IMP ANCHR V-LOX 5.5MM Ti" as identified in the itemized statement and labeled on the invoice as "5.5mm v-lox titanium suture anchor w/three #2 Parcus braid sutures" with a cost per unit of $531.00.

   The total net invoice amount (exclusive of rebates and discounts) is $3,066.00. 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-ons per admission is $306.60. The total recommended reimbursement amount for the implantable items is $3,372.60.

8. The total recommended payment for the services in dispute is $13,787.71. The insurance carrier has paid $2,852.52. The amount due to the requestor is $10,935.19. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

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 $10,935.19.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $10,935.19, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	September 2, 2016
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 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.