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
Baylor Orthopedic & Spine Hospital

Respondent Name
Sentry Casualty Co

MFDR Tracking Number
M4-17-3437-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting 130% of the Medicare allowable with implant reimbursement: Total reimbursement due = $9,634.30."

Amount in Dispute: $2,571.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "When we received the dispute, there still wasn't a corrected billing. I called and discussed the implants with her. She ended up needing to verify the statement that the TOTAL was $6,000.00 not the one line. She sent me an email stating it indeed was the TOTAL, so I did an adjustment, using the certification sheet and pricing on the implants. The implants were paid at $1,304.71 + 10% for a total of $1,435.18. The claim is now paying less ($2,593.11) with the separate allowance of the implants. The final explanation of benefits is Exhibit 3. Please accept this as resolution to the dispute filed."

Response Submitted by: Sentry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2016	Outpatient Hospital Services	$2,571.72	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital

services.

3. 28 Texas Administrative Code §134.1 outlines the guidelines for medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $2,571.72 for implants that were provided during an outpatient hospital procedure on November 11, 2016.

   The insurance carrier denied disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment." 28 Texas Administrative Code §134.403 (e) states,

   > 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 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).

28 Texas Administrative Code §134.403 (f) states,

> 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 Outpatient Prospective Payment System (OPPS) 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) 200 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 130 percent.

Review of the submitted medical bill finds in box 56 the NPI number 1346570710. Review of the National Plan & Provider Enumeration System at https://npiregistry.cms.hhs.gov finds no Medicare number associated with this NPI. Therefore as no "Medicare facility specific amount" can be determined per the requirements of 28 Texas Administrative Code §134.403 (f). Therefore, the division concludes that §134.1(f) applies and states,

> 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.

For that reason, 28 Texas Administrative Code §133.307(c)(2)(O) also applies and, 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."

Review of the submitted documentation finds:

- The requestor does not discuss or demonstrate how requested reimbursement is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- 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(f).

2. For the reasons stated, the division concludes that the requestor failed to support its request for reimbursement. For that reason, no reimbursement can be recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 21, 2017
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 Rule §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. **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.