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
VIBRA SPECIALTY HOSPITAL OF DESOTO

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-19-3614-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 27, 2019

Response Submitted By
Avidel

REQUESTOR'S POSITION SUMMARY

"As per terms of our contract with Prime Networks inpatient hospital claims are to pay at 95% of the DRG rate established by Medicare…. 143% of DRG 560 pays $65542.28 for 18 days at this facility and we were only paid $20,901.56 resulting in an underpayment of $14640.72."

RESPONDENT'S POSITION SUMMARY

"We are upholding the original review's and where paid at Fee schedule."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 8, 2018 to June 26, 2018	Long-Term Care Hospital (LTCH) Inpatient Services	$14,640.72	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §134.404 sets out the division's *Hospital Facility Fee Guideline—Inpatient*.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 756 – PER RULE 133.25 PROVIDER MAY NOT SUBMIT RECONSIDERATION AFTER THE CARRIER HAS TAKEN FINAL ACTION. SEEK MDR IN ACCORDANCE TO RULE 133.307.
   - 468 – REIMBURSEMENT IS BASED ON THE MEDICAL HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM METHODOLOGY.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 224 – DUPLICATE CHARGE.
   - 758 – BILL WAS NOT SUBMITTED TIMELY IN ACCORDANCE WITH DWC CHAPTER 133.

Issues

1. Are the disputed services subject to a contract between the parties to this dispute?
2. What is the applicable rule for determining reimbursement of long-term care hospital services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor's position statement asserts, "As per terms of our contract with Prime Networks inpatient hospital claims are to pay at 95% of the DRG rate established by Medicare."

   Based on information known to the division, the injured employee is not enrolled in a workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305, nor is the injured employee's claim subject to a certified workers' compensation HCN.

   Neither party presented documentation to support a contractual agreement between the parties to this dispute.

   The division therefore concludes that reimbursement for the disputed services is not subject to a contracted rate.

2. This dispute involves payment for hospital services provided by a long-term care facility.

   The requestor asserts reimbursement should be "143% of DRG … for 18 days" in accordance with Rule §134.404(f)(1)(A), which requires that:

   > the 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 … multiplied by … 143 percent

   The NPI number listed in box 56 of the medical bill identifies the medical provider as a *long-term care* hospital. Long-term care hospitals are not paid under the Medicare IPPS, but instead have a separate payment system: Medicare's Long-Term Care Hospital Prospective Payment System — which has not been adopted by the division as a basis for reimbursement under any division fee guideline. Consequently, a payment amount cannot be determined using the formula in Rule §134.404(f).

   Rule §134.404(e)(3) provides that "If no contracted fee schedule exists … and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) … reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

   28 Texas Administrative Code §134.1(f) requires 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. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004). Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach … reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

In the following analysis, the submitted information is examined to determine which party presents the best evidence to support a payment that achieves a fair and reasonable reimbursement for the services in dispute. The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

3. The division first considers whether the requestor has met the burden to support that the payment amount requested is a fair and reasonable rate of reimbursement for the services in dispute. If the requestor's evidence is persuasive, the division will then review the evidence presented by the respondent.

   Review of the submitted documentation finds that:

   - The requestor asks for payment according to the Medicare Inpatient Prospective Payment System formula multiplied by 143%.
   - The requestor is not an acute care hospital, but rather a long-term care hospital (LTCH); payment cannot be calculated using the Medicare IPPS formula.
   - The requestor did not explain or provide documentation to support why an economic adjustment factor of 143% should apply to LTCH services.
   - The requestor did not explain or provide documentation to support how the proposed methodology ensures quality medical care to injured workers.
   - The requestor did not explain or provide documentation to support how the proposed methodology achieves effective medical cost control.
   - The requestor did not explain or provide documentation to support how the proposed methodology ensures that similar procedures provided in similar circumstances receive similar reimbursement.
   - The requestor did not explain or provide documentation to support that the proposed methodology is consistent with the criteria of Labor Code §413.011.
   - The requestor did not explain or provide documentation to support that the proposed methodology satisfies the requirements of Rule §134.1.

   The request for additional reimbursement is not supported. The division concludes the requestor failed to discuss, demonstrate, and justify by a preponderance of the evidence that the payment sought is a fair and reasonable rate of reimbursement for the services in dispute. Consequently, additional payment cannot be 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

The applicable rule for determining reimbursement of the disputed long-term care hospital services is 28 Texas Administrative Code §134.1, regarding a fair and reasonable reimbursement.

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

ORDER

In accordance with the provisions of Texas Labor Code §413.031, based on the information submitted for review, the division determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	June 14, 2019
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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.