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

Texas Health Plano

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-20-2402-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

June 3, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have verified there is no PPO reduction. We have submitted this claim for a reconsideration and the carrier denied our request."

Amount in Dispute: $1,154.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant is in the Coventry Health Care Network. Medical fee disputes involving network claims are to be handled through the network itself. …Since this is a network medical fee dispute, it should be handled by the network itself and not by the Division's Medical Review Division."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 7 – 8, 2019	Inpatient Hospital Services	$1,154.92	$1,129.60

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 §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 94 – Processed in excess of charges

Issues

1. Is the respondent's position supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. The respondent states in their position statement, "The claimant is in the Coventry Health Care Network."

   Coventry Health Care Network is listed as a certified network on the Division's webpage but the carrier did not provide convincing evidence that the injured employee is enrolled in this network, nor did the carrier provide documentation to support that the requestor is contracted with Coventry Health Care Network.

   The respondents' position is not supported, the services in dispute will be reviewed per applicable fee guidelines.

2. The requestor is seeking additional reimbursement for inpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.404(f), requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Separate reimbursement for implantables was not requested; accordingly, Rule §134.404(f)(1)(A) requires that, for these services, the Medicare facility specific amount, including any outlier payment, be multiplied by 143%.

   Note: the "VBP adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system. However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system. Rule §134.404(d)(1) requires that specific Labor Code provisions and division rules take precedence over conflicting CMS provisions for administering Medicare. Consequently, VBP adjustments are not considered in determining the facility reimbursement.

3. Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 090. The service location is Plano, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $6,744.81. This amount multiplied by 143% results in a MAR of $9,645.08.

   The total recommended payment for the services in dispute is $9,645.08. The insurance carrier has paid $8,515.48. The amount due to the requestor is $1,129.60. This amount is 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 $1,129.60.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,129.60, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

_______________	[redacted]	July 15, 2020
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.