



# 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

**Requester Name**

ORANGE PARK MEDICAL CTR

**Respondent Name**

ACE AMERICAN INSURANCE CO

**MFDR Tracking Number**

M4-21-0103-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

September 21, 2020

#### REQUESTER'S POSITION SUMMARY

"Our information indicates that this patient's injury gave rise to a workers' compensation claim having its jurisdiction in the State of Texa. However, the medical treatment underlying the account charges was rendered in the State of Florida, where the Hospital is located. Neither State's Workers' Compensation Laws can be applied to adjudicate and determine reimbursement for the medical treatment for this account. Rather, this account's reimbursement is governed solely by the patient's contract with the Hospital, the Conditions of Admission, wherein the patient promised to pay the Hospital's Charge Master in effect on the date services were rendered. Accordingly, the Hospital is expecting payment in full."

**Amount in Dispute:** \$498,118.69

#### RESPONDENT'S POSITION SUMMARY

"ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of \$43,241.23. Any claims that originalte in Texas must be reviewed according to Texas rules regardless of where the service is actually rendered."

**Response Submitted by:** ESIS Bill Review

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 8-15, 2020	Inpatient Hospital Services	\$498,118.69	\$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 (DWC).

**Background**

1. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission.

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 fee guidelines for inpatient hospital facilities.
4. Texas Labor Code §408.027 gives requirements for reimbursement of medical bills.
5. Texas Labor Code §413.042 addresses private claims against injured employees.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - Out of state provider: Reimbursement based on out-of-state provider section of the fee schedule. (94)
  - Charge(s) are included in the per diem reimbursement. (988)
  - Reduction is based on the Inpatient Fee Schedule. (993)
  - P12 – Workers compensation jurisdictional fee schedule adjustment.
  - Note: “Additional recommended allowance of \$2677.76 is being made based upon additional supporting documentation received.”
  - A technical Bill Review (TBR) has been performed. (ETBR)
  - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
  - This appeal is denied as we find ethe original review reflected the appropriate allowance for service rendered. We did find that no additional recommendation is warranted at this time. (CIQ378)
  - This procedure on this date was previously reviewed (148)
  - 18 – Duplicate claim/service. (ANSI18)

### **Issues**

1. Does the Texas Department of Insurance/Division of Workers’ Compensation have jurisdiction to review this dispute?
2. Is Orange Park Medical Center limited to reimbursement according to the fee guidelines outlined in the Texas Workers’ Compensation Act?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is Orange Park Medical Center entitled to additional reimbursement for the services in question?

### **Findings**

1. The requester provided inpatient hospital services in the state of Florida April 8 – 15, 2020, to an injured employee with an existing Texas Workers’ Compensation claim. The requester was dissatisfied with the respondent’s final action. The requester filed for reconsideration and was denied payment after reconsideration. The requester filed for dispute resolution.<sup>1</sup>

No evidence was provided to indicate an agreement with the insurance carrier regarding fees. The DWC concludes that because the requester sought the administrative remedy outlined in 28 TAC §133.307 for resolution of this dispute, the dispute is to be decided under the jurisdiction of the Texas Workers’ Compensation Act and applicable rules.

2. In its position statement, Orange Park Medical Center stated, “this account’s reimbursement is governed solely by the patient’s contract with the Hospital, the Conditions of Admission, wherein the patient promised to pay the Hospital’s Charge Master in effect on the date services were rendered.”

No evidence was provided that any negotiated fee amount was discussed with the insurance carrier. Orange Park Medical Center provided no evidence that the injured employee agreed to accept liability for reimbursement of any remaining balance after the insurance carrier paid the submitted bill.

The Texas Workers’ Compensation Act prohibits a health care provider from billing or attempting to collect any remaining balance from the injured employee after the insurance carrier has reimbursed the bill according to applicable fee guidelines.<sup>2</sup>

The DWC concludes that Orange Park Medical Center is limited to reimbursement according to the fee guidelines outlined in the Texas Workers’ Compensation Act.

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<sup>1</sup> 28 TAC §133.307

<sup>2</sup> 28 TAC §133.20 (l) and TLC §408.042 (a)

3. This dispute regards inpatient hospital facility services with payment subject to 28 TAC §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 (CMS) at <http://www.cms.gov>.

Separate reimbursement for implantables was not requested. Accordingly, the Medicare facility specific amount for these services, including any outlier payment, are multiplied by 143 percent.<sup>3</sup>

Note: Medicare’s Value-Based Purchasing (VBP) adjustment listed in the PC Pricer was removed in calculating the facility amount for this admission. The 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 431.0512 regarding review and monitoring of health care quality in the Texas workers’ compensation system. Specific Labor Code provisions and DWC rules take precedence over conflicting CMS provisions for administering Medicare.<sup>4</sup> Consequently, VBP adjustments are not considered in determining the facility reimbursement.

4. Because the DWC has determined that the requester is subject to the fee guidelines found in the Texas Workers’ Compensation Act, the payment made by the insurance carrier will be evaluated based on these rules.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 958. The service location is at Orange Park Medical Center in Orange Park, Florida. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$29,873.26. This amount, multiplied by 143 percent results in a MAR of \$42,718.76.

Review of the submitted documentation finds that ACE American Insurance Company paid \$43,241.23. The DWC finds that Orange Park Medical Center is not entitled to additional reimbursement for the services in question.

**Conclusion**

For the reasons stated above, the DWC finds that the requester 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 DWC hereby determines the requester is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

_____	_____	December 10, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	Dec. 10, 2020
Signature	Deputy Commissioner	Date

<sup>3</sup> 28 TAC §134.404 (f)(1)(A)

<sup>4</sup> 28 TAC §134.404 (d)(1)

## ***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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.**