Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MAINLAND MEDICAL CENTER
3701 KIRBY DR STE 1288
HOUSTON TX 77098-3916

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-8997-01

MFDR Date Received
May 14, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier failed to pay in accordance with Inpatient Fee Schedule."

Amount in Dispute: $6,962.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2008	Inpatient Hospital Surgical Services	$6,962.37	$6,962.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the fee guidelines for inpatient hospital facility services.
3. Per §133.307(d), "Responses to a request for MDR shall be legible and submitted to the Division and to the requestor in the form and manner prescribed by the Division. (1) Timeliness. The response will be deemed timely if received by the Division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information. (2) Carrier Response. Upon receipt of the request, the carrier shall complete the required sections of the request form and provide any missing information not provided by the requestor and known to the carrier." The insurance carrier's Austin representative signed for and acknowledged receipt of a copy of the

request for medical fee dispute resolution on June 12, 2009. The insurance carrier did not submit a response for consideration in this dispute. The Division concludes that the insurance carrier has not met the requirements of §133.307(d). This decision is therefore based on the information available at the time of review.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 770 – COMPLEX BILL REVIEW.
   - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT
   - 793 – REDUCTION DUE TO PPO CONTRACT.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 793 – "REDUCTION DUE TO PPO CONTRACT." Review of the submitted information found no documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 21, 2010, pursuant to 28 Texas Administrative Code §133.307(e)(1), effective May 25, 2008, 33 *Texas Register* 3954, which states that "The Division may request additional information from either party to review the medical fee issues in dispute," the Division requested the respondent to provide a copy of the referenced contract(s) between the alleged network and the requestor, as well as documentation to support notice to the hospital that the insurance carrier, Zurich American Insurance Company, was authorized to access the requestor's network fee agreement. While the respondent did submit documentation to support a contractual fee arrangement between the health care provider and the alleged network referenced on the explanation of benefits, the contract was dated in 2004. No documentation was found to support whether the contract was in effect on the dates of service in 2008. Moreover, no documentation was submitted to support that the insurance carrier, Zurich American Insurance Company, was entitled to access the requestor's alleged contractual fee arrangement with the network on the date of the disputed services. The respondent presented no contract between the insurance carrier and the alleged network to establish that the insurance carrier was authorized, and under what terms allowed, to access the requestor's alleged network fee arrangement. Nor was any list of authorized payors found with the submitted materials to show that Zurich American Insurance was an authorized payor under the terms of the alleged contract on the date that the disputed services were provided. The Division notes that article 1.6 of the submitted contract requires that the network "will supply Contract Facility with a list of all Payors that have entered into Payor Agreements to utilize the Preferred Provider Panel." Additionally, at article 3.13, the submitted contract requires that the network "shall periodically provide Contract Facility with an up-to-date list of all Payors and shall promptly advise Contract Facility, in writing of any changes in the Payor list." Furthermore, article 1.3 requires that "any notice required to be given pursuant to the terms and provisions of the Contract shall be in writing and shall be sent by overnight mail or certified mail, return receipt requested." Review of the submitted documentation finds no such list of payors. Nor was any documentation submitted to support that the hospital had been notified of such a list in writing by mail, pursuant to the notice provisions in the contract. Nor was any documentation submitted to support that the requestor was specifically notified, in accordance with the terms of the contract, that Zurich American Insurance Company was an authorized network payor. While the respondent did submit a copy of a September 2008 newsletter containing a list of health care networks, it does not contain a list of contracted payors. The Division further notes that the date of the newsletter is several months after the date of service in dispute. Further, the address on the accompanying envelope is, though obscured, clearly not the address of the requestor. Lastly, the newsletter does not list the name of Zurich American Insurance Company. While it does list the name of Zurich Services Corporation Healthcare Network, no documentation was found to support that Zurich Services Corporation Healthcare Network is the same as Zurich American Insurance Company, and no information was found to support that a person could reasonably conclude from the documentation as submitted that Zurich American Insurance Corporation was an authorized payor under the terms of the alleged contract. After considering all the submitted documentation, the Division concludes that the respondent has failed to support that the insurance carrier, Zurich American Insurance Company, was entitled to access a contractual fee arrangement between the health care provider and the alleged network. Moreover, the respondent has failed to establish that the disputed services are subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011. The above payment reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. Review of box 4 of the medical bill for the disputed services finds that the Type of Bill code is 111, which indicates facility services performed in an inpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.404, the *Hospital Facility Fee Guideline – Inpatient*. Per §134.403(f), 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 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 in accordance with subsection (g). Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Per §134.404(f)(1)(A) the maximum allowable reimbursement (MAR) is calculated by multiplying the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount, determined in accordance with the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 578. The services were provided at Mainland Medical Center. Consideration of the assigned DRG, location of the services, and bill-specific information results in a total Medicare facility specific reimbursement amount of $6,403.82. This amount multiplied by 143% results in a MAR of $9,157.46.

4. The maximum allowable reimbursement for the disputed services is $9,157.46. This amount less the amount previously paid by the insurance carrier of $2,195.10 leaves an amount due to the requestor of $6,962.36. 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 $6,962.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,962.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	[redacted] Medical Fee Dispute Resolution Officer	January 16, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.