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
PINE CREEK MEDICAL CENTER

Respondent Name
CHARTER OAK FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-09-9356-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
June 12, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is confusing as to how the carrier audited this claim, part of the charges are paid according to the contracted rate, and the other part of the charges are paid according to the Maximum fee schedule amount established by applicable law. Carrier should choose the lesser of one or the other, and not the lesser of both."

Amount in Dispute: $209.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the newly adopted Ambulatory Surgical Center Fee Guideline allows for less reimbursement than the contract, as the 10% markup on the implantables is capped at $2000.00. As the Provider submitted invoices for over $20,000 of implantables, the markup was capped per the applicable state fee schedule."

Response Submitted by: Travelers (Charter Oak), 1501 South MoPac Expressway, Ste. A-320, Austin, Texas 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2008 to June 19, 2008	Inpatient Hospital Services	$209.40	$209.40

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 medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the fee guidelines for inpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - DPAY – W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICED IN ACCORDANCE WITH THE DRG RATE.
   - INCG – W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICING INCLUDED IN THE DRG RATE.
   - FEES – W1 - WORKERS COMPENSATION STATE F/S ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S, OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.

- F03B – A2 - CONTRACTUAL ADJUSTMENT. ANY REDUCTION IS IN ACCORDANCE WITH FOCUS/AETNA WORKER/S COMP ACCESS LLC. FOR QUESTIONS REGARDING NETWORK REDUCTION, PLEASE CALL 1-800-243-2336.
- T114 – W1 - WORK COMP STATE FEE SCHEDULE ADJUSTMENT. REIMBURSEMENT WAS BASED ON THE INVOICE COST PLUS ANY APPLICABLE STATE MARKUP.
- Z10F – W4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION. AFTER CAREFULLY RE-VIEWING THE RESUBMITTED INVOICE, ADDITIONAL REIMBURSEMENT IS NOT JUSTIFIED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code F03B A2 – CONTRACTUAL ADJUSTMENT. ANY REDUCTION IS IN ACCORDANCE WITH FOCUS/AETNA WORKER/S COMP ACCESS LLC. FOR QUESTIONS REGARDING NETWORK REDUCTION, PLEASE CALL 1-800-243-2336." No documentation was found to support a contractual fee agreement between the insurance carrier, Charter Oak Fire Insurance Company and the health care provider. No documentation was found to support a contract between Charter Oak Fire Insurance Company and the third party insurance network referenced on the explanations of benefits. The respondent did not submit documentation to support that the insurance carrier, Charter Oak Fire Insurance Company, had been granted access to the contractual fee agreement between the health care provider and the alleged insurance network. The Division finds that the insurance carrier has failed to support this payment reduction reason. Reimbursement will therefore be considered per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient acute care hospital services with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.404(f) which provides that "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. 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) 143 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 108 percent." Additionally, subsection (g) requires that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Documentation was found to support that the facility requested separate reimbursement for implantables; for that reason, the MAR is calculated according to §134.404(f)(1)(B).

   Per §134.404(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

   §134.404(f)(2) further requires that when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.404(g). The facility's total billed charges for the separately reimbursed implantable items are $110,470.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments.
3. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 460, and that the services were provided at Pine Creek Medical Center in Dallas, Texas. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $29,287.43. This amount multiplied by 108% results in a MAR of $31,630.42. Review of the submitted explanations of reimbursement support that the insurance carrier paid $30,454.00 for the hospital services. However, according to the requestor's *Table of Disputed Services*, reimbursement for the hospital services is not in dispute; therefore, additional reimbursement cannot be recommended for those services.

According to the requestor's *Table of Disputed Services*, the items remaining in dispute are the implantable items. Review of the submitted documentation finds that the separate implantables include:

- "IMP MEDT INFUSE MED" as identified in the itemized statement and labeled on the invoice as "BIOLOGIC 7510400 INF BONE FRAFT MD KIT" with a cost per unit of $4,692.00;
- "IMP MEDT PLT COVER M ALIF" as identified in the itemized statement and labeled on the invoice as "COVER PLATE 7962330 MEDIUM" with a cost per unit of $2,000.00;
- "IMP MEDT MASTRGRF MARIX 20CC" as identified in the itemized statement and labeled on the invoice as "BIOLOGICS 7600320 MASTRGRFT MATRX 20CC KT" with a cost per unit of $1,200.00;
- "IMP MEDT INFUSE LEG II" as identified in the itemized statement and labeled on the invoice as "BIOLOGICS 7510800 INFUSE BFRFT LRGII KIT" with a cost per unit of $5,202.00;
- "IMP MEDT CAGE 37X27X14MM 8DEG" as identified in the itemized statement and labeled on the invoice as "SPACER 7962814 M 37 X 27 14 MM 8 DEG" with a cost per unit of $6,000.00; and
- "IMP MEDT SCR 6.5 X 25MM" as identified in the itemized statement and labeled on the invoice as "SCREW 7960025 5.5 X 25MM SELF-TAP" with a cost per unit of $3,000.00 at 3 units, for a total cost of $9,000.00.

The total net invoice amount (exclusive of rebates and discounts) is $28,094.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $2,000.00. The total recommended reimbursement amount for the implantable items is $30,094.00. Review of the submitted explanations of reimbursement support that the insurance carrier paid $24,094.00 for the implantable items.

4. The total allowable reimbursement for the items in dispute is $30,094.00. The amount previously paid by the insurance carrier is $24,094.00. The requestor is seeking additional reimbursement in the amount of $209.40. 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 $209.40.

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 $209.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 27, 2014
Signature	Medical Fee Dispute Resolution Officer	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.