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
Baylor Orthopedic & Spine Hospital

Respondent Name
Merged Royal Insurance Co of America Into Arrowood Indemnity

MFDR Tracking Number
M4-17-2878-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
May 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following claim was not processed according to Texas fee guidelines for inpatient services."

Amount in Dispute: $19,417.12

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Merged Royal Insurance Co of America Into Arrowood Indemnity is Cunningham Lindsey Group Ltd. Cunningham Lindsey Group Ltd acknowledged receipt of the copy of this medical fee dispute on June 6, 2017.

28 Texas Administrative Code §133.307(d)(1) states:

> Responses. Responses to a request for MFDR 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.

Review of the documentation finds that no response has been received from Cunningham Lindsey Group Ltd to date. The Division concludes that the carrier failed to respond within the timeframe required by §133.307(d)(1). For that reason the Division will base its decision on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9 – 12, 2017	Inpatient Hospital Services	$19,417.12	$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.

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 reimbursement guidelines for inpatient hospital services.
3. 28 Texas Administrative Code §134.1(f) which details medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 5444 – Please resubmit with detailed implant log along with invoices. This information is necessary for accurate repricing of the implantable device charges
   - 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical. Please expect a detailed explanation of review and direct all surgical implant inquiries to ForeSight Medical at 813-930-5346.

Issues

1. What is the applicable fee rule?
2. Did the requestor provide documentation to support requested payment amount?

Findings

1. The requester seeks additional reimbursement in the amount of $19,417.12 for services rendered during an inpatient hospital stay from January 9, 2017 – January 12, 2017.

   The carrier reduced the payment with the following reason 6981 – "Charges for surgical implants are reviewed separately by ForeSight Medical. Please expect a detailed explanation of review and direct all surgical implant inquiries to ForeSight Medical at 813-930-5346."

   The service in dispute of inpatient hospital services are subject to 28 Texas Administrative Code 134.404 (e) which states in pertinent parts,

   > Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   > (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   > (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.
   > (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

   Texas Administrative Code §134.404 (f) states,

   > 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.

Review of the submitted medical bill found an NPI number of 1346570710. Research of the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov/#/, found no Medicare provider number associated with this NPI. Therefore, the Medicare facility specific amount utilizing the Medicare Inpatient Prospective Payment System (IPPS) could not be determined. The services in dispute are therefore subject to 28 Texas Administrative Code 134.404 (e) (3) referenced above.

2. Texas Administrative Code §134.1 (f) states,

   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.

   28 Texas Administrative Code §133.307(c)(2)(O) also applies and, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

   Review of the submitted documentation found:

   - The requestor does not discuss or demonstrate how reimbursement of $19,417.12 is a fair and reasonable reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1(f).

   For the reasons stated, the division concludes that the requestor failed to support its request for reimbursement. Therefore, no reimbursement can be recommended.

Conclusion

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

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 24, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 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 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 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 §141.1(d).

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