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
BAPTIST ST. ANTHONY'S HEALTH

Respondent Name
INSURANCE COMPANY OF THE WEST

MFDR Tracking Number
M4-20-0659-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
November 12, 2019

Response Submitted By
Mitchell International, Inc.

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for consideration in this review.

RESPONDENT'S POSITION SUMMARY

"inpatient hospital service were paid per the Medicare fee without implants at a markup of 143% minus a preferred provider contract reduction for an a total allowance of $37,857.14."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 6, 2019 to June 14, 2019	Inpatient Hospital Services	$34,854.00	$27,144.51

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC) in Title 28, Part 2 of the Texas Administrative Code.

Background

1. 28 Texas Administrative Code §133.240 sets out requirements regarding medical bill payments and denials.
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 hospital facility fee guideline for inpatient services.
4. 28 Texas Administrative Code §134.807 sets out state specific requirements for carrier medical bill reporting.
5. Texas Labor Code §402.082 requires DWC to maintain certain information on every compensable injury.
6. Texas Labor Code §413.011 sets out requirements for carriers and certified networks to contract with providers.
7. Texas Insurance Code Chapter 1305 sets out requirements for certified workers' compensation health care networks.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 252 – an attachment/other documentation is required to adjudicate this claim/service.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
   - M127 – Missing patient medical record for this service.
   - MA27 – Missing/incomplete/invalid entitlement number or name shown on the claim.
   - MA30 – Missing/incomplete/invalid type of bill.

- N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
- 131 – CLAIM SPECIFIC NEGOTIATED DISCOUNT.
- 253 – IN ORDER TO REVIEW THIS CHARGE WE WILL NEED A COPY OF THE INVOICE..
- 468 – REIMBURSEMENT IS BASED ON THE MEDICAL HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM METHODOLOGY.
- 751 – NEGOTIATED CONTRACT PRICE.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- PDC – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS, PLEASE CALL 1-800-937-6824
- 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Is payment for the disputed services subject to a certified workers' compensation health care network (HCN) established under Texas Insurance Code Chapter 1305?
2. Is payment for the disputed services subject to a claim specific negotiated discount or contracted price?
3. Is the requestor entitled to additional payment?

Findings

1. The respondent's position statement asserts the services "were paid per the Medicare fee without implants at a markup of 143% minus a preferred provider contract reduction..."

   Labor Code §402.082(a)(3) requires DWC to maintain information on every compensable injury as to the "identification of whether the claimant is receiving medical care through a workers' compensation health care network certified under Chapter 1305, Insurance Code."

   Based on information maintained by DWC, the claim for the employee's injury is not subject to any network.

   28 Texas Administrative Code (TAC) Chapter 134, Subchapter I, sets out reporting requirements for all insurance carriers for each medical bill; including Rule 28 TAC §134.807(f)(7), which requires carriers to report whether services were performed within a certified workers' compensation HCN or under a contractual fee arrangement for each medical bill on a workers' compensation claim.

   The insurance carrier has not previously reported to DWC that these services were performed within a certified network or under a contractual fee arrangement. Nor did the response contain any documentation to support the claim is subject to a certified workers' compensation HCN established under Chapter 1305, Insurance Code.

   Moreover, Rule 28 TAC §134.240(f)(15) requires the carrier's explanation of benefits (EOB) to include the "workers' compensation health care network name (if applicable)" when the carrier pays or denies a bill.

   The submitted EOBs list the name of the applicable PPO network as "Coventry Integrated Network."

   Based on information known to DWC, the name "Coventry Integrated Network" is not certified as a workers' compensation HCN established under Insurance Code Chapter 1305.

   The division therefore concludes the disputed services are not subject to the provisions of a certified workers' compensation HCN established under Texas Insurance Code Chapter 1305.

2. The insurance carrier reduced payment for disputed services with claim adjustment reason codes:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
   - 131 – CLAIM SPECIFIC NEGOTIATED DISCOUNT.
   - 751 – NEGOTIATED CONTRACT PRICE.
   - PDC – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS, PLEASE CALL 1-800-937-6824

   DWC's *Hospital Facility Fee Guideline – Inpatient*, Rule 28 TAC §134.404(e) requires, 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.

   Labor Code §413.011 (d-4) provides, "an insurance carrier, an insurance carrier's authorized agent, or a network certified under Chapter 1305, Insurance Code, arranging for non-network services or out-of-network services under Section 1305.006, Insurance Code, may continue to contract with a health care provider to secure health care for an injured employee for fees that exceed the fees adopted by the division..."

   No information was provided to support a contracted fee arrangement, claim specific negotiated discount, negotiated contract price or contract that complies with Labor Code §413.011.

   Consequently, Rule 28 TAC §134.404(e)(2) requires reimbursement to be the maximum allowable reimbursement (MAR) amount under Rule 28 TAC §134.404 subsection (f).

3. This dispute regards inpatient services with payment subject to DWC *Hospital Facility Fee Guideline—Inpatient*, Rule 28 TAC §134.404, requiring maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors with modifications set out in the rules. Medicare IPPS formulas and factors are available from http://www.cms.gov.

   Separate reimbursement for implantables was not requested; accordingly, Rule 28 TAC §134.404(f)(1)(A) requires payment for these services to be 143% of the Medicare facility specific amount, including any outlier payment.

   DWC calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is also freely available from www.cms.gov.

   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.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 025. The service location is Amarillo, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $45,455.70. This amount multiplied by 143% results in a MAR of $65,001.65.

   The total allowable reimbursement for the services in dispute is $65,001.65. The amount previously paid by the insurance carrier is $37,857.14. The amount remaining due is $27,144.51. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, DWC finds that additional payment is due. As a result, the amount ordered is $27,144.51.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $27,144.51, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	January 9, 2020 Date
Signature	Martha Luévano Director of Medical Fee Dispute Resolution	January 9, 2020 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 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

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