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

TRIUMPH HEALTHCARE CLEARLAKE
7333 NORTH FWY STE 500
HOUSTON TX 77076-1322

Respondent Name
HARRIS COUNTY

Carrier's Austin Representative Box
Box Number 21

MFDR Tracking Number
M4-12-0304-01

MFDR Date Received
September 26, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per TX Work Comp Fee Schedule, carrier is to pay 143% of MCR DRG rate."

Amount in Dispute: $9,857.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Triumph Hospital Clear Lake is classified as a long term facility. Since they are not an acute care facility as required by the rule 134.404, the Inpatient Hospital Fee Guideline does not apply. As such, the Carrier had to establish a fair and reasonable allowance for reimbursement in this matter. . . . The Carrier has reimbursed $11,250.00 in this matter which is more reimbursement than would have been received in an acute care facility. The attached information establishes that the amount of reimbursement provided was fair and reasonable for a long care facility and no additional allowance is recommended."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, LC, 912 S. Capital of Texas Highway, Suite 300, Austin, Texas 78746-5242

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2011 to April 13, 2011	Inpatient Hospital Services	$ 9,857.56	$0.00

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 hospital services
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent alleges that "Triumph Hospital Clear Lake is classified as a long term facility. Since they are not an acute care facility as required by the rule 134.404, the Inpatient Hospital Fee Guideline does not apply." Per 28 Texas Administrative Code §134.404(a)(1), effective March 1, 2008, 33 *Texas Register* 400, the Division's *Hospital Facility Fee Guideline—Inpatient*, applies to "medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008." Subsection (b)(1) defines an acute care hospital as "a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma." Review of records held by the Texas Department of State Health Services finds that the health care facility is an appropriately licensed general hospital, authorized to provide inpatient and outpatient medical services to patients experiencing acute illness or trauma. Review of the medical bill submitted by the requestor finds that the services in dispute are billed as acute care inpatient hospital services. Review of Medicare payment policies finds that an amount can be determined by application of the formula to calculate the MAR as outlined in §134.404(f). Review of the information submitted by the respondent finds insufficient documentation to support that the *Hospital Facility Fee Guideline—Inpatient*, does not apply to the services in dispute. Accordingly, the Division concludes that the appropriate rule for reimbursement is §134.404, the *Hospital Facility Fee Guideline—Inpatient.*
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.404, which requires 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 with 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 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested. Reimbursement for the disputed services is calculated as follows:

   The Medicare facility-specific reimbursement amount, including outlier payment amount, for DRG code 189 is $7,729.92. This amount multiplied by 143% yields a total maximum allowable reimbursement (MAR) of $11,053.7856. This amount less the amount previously paid by the insurance carrier of $11,250.00 leaves an amount due to the requestor of $0.00. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the requestor has failed to establish 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 reimbursement for the services in dispute.

Authorized Signature

Signature	[redacted] Medical Fee Dispute Resolution Officer	February 14, 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.