



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

FRISCO MEDICAL CENTER

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-0053-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

September 04, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by FRISCO MEDICAL CENTER to audit their Workers Compensation claims. We have found in this audit there is a discrepancy in regards to the appropriate reimbursement according to the Title 28 Chapter 134.404 (f) (1): Effective 03/01/08, an Inpatient admission is reimbursed by applying the IPPS Medicare pricer allowable x 143%.

Medicare would have allowed this facility \$11,902.30 for MS DRG 66. A Medicare Pricer Program printout has been attached for your reference. **The correct allowable is \$17,020.29, which is 143%-over-Medicare.** After your payment of \$16,902.04, **a balance of \$528.25 still remains."**

Amount in Dispute: \$585.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance Company received a TWCC-60 from the above mentioned requester. Pursuant to Commission Rule 133.307(d). Texas Mutual files the attached, completed response, and related items.

The following is the carrier's statement with respect to this dispute of 11/26/12 through 11/29/12. The requestor provided inpatient surgical services to the claimant on the dates above. The requestor states the correct reimbursement amount is to be derived from the 2013.1 04/13 IPPS PRICER calculated rate multiplied by the DWC payment adjustment factor. That is, \$11,902.30 from DRG 470 multiplied by 143% to get \$17,020.29, as the correct MAR. Texas Mutual does not agree per the following:"

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2012 to November 29, 2012	Inpatient Hospital Surgical Services	\$585.46	\$528.25

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 guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated
 - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly
 - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 217 – The value of this procedure is included in the value of another procedure performed on this date
 - 420 – Supplemental payment
 - 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
 - 891 – No additional payment after reconsideration

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. 28 Texas Administrative Code §134.404(e) states that: “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.”

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states 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.”

No 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)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. 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 470, and that the services were provided at Frisco Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$11,902.30. This amount multiplied by 143% results in a MAR of \$17,020.29.
1. The division concludes that the total allowable reimbursement for the services in dispute is \$17,020.29. The respondent issued payment in the amount of \$16,492.04. Based upon the documentation submitted, additional reimbursement in the amount of \$528.25 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

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 \$528.25 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

7/3/2014

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, effective May 31, 2012, 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 MDR 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.