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

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ECTOR COUNTY HOSPITAL

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-14-1169-02

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 27, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the applicable Texas fee schedule the correct allowable would be per the DRG 491. The allowable for this DRG per Medicare is $7342.66, we have also attached the print out for your review form the Medicare pricer program. The correct allowable would be at 143% making the allowable at $10500.00. Based on your payment of $10319.74, there is an additional of $180.26, still due at this time."

Amount in Dispute: $74.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per our bill review there is an additional payment due of $105.71 for the dates listed above and will be issued."

Response Submitted by: Gallagher Bassett Services, Inc., 16414 San Pedro Ave., Ste. 950, San Antonio, Texas 78232

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2013 to January 15, 2013	Inpatient Hospital Services	$74.55	$74.55

AMENDED FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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 requestor submitted an amended *Table of Disputed Services* after receipt of additional payment from the respondent, subsequent to the filing of this dispute. The requestor has amended the table to indicate a revised amount in dispute. The amount in dispute above is the amount as listed on the requestor's amended table.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

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, reimbursement shall be the MAR as 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 the 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. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 491. The services were provided at Medical Center Hospital, Odessa. Consideration of the DRG, service location, and bill-specific information results in a total Medicare facility specific allowable amount of $7,342.66. This amount multiplied by 143% results in a MAR of $10,500.00.
4. The total recommended payment for the services in dispute is $10,500.00. This amount less the amount previously paid by the insurance carrier of $10,425.45 leaves an amount due to the requestor of $74.55.

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 $74.55.

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 $74.55 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	May 8, 2014 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, 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.