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
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
MCALLEN ISD

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-15-1477-01

MFDR Date Received
January 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.402 Facility Fee Guideline-Inpatient states that the reimbursement is 143% of the Medicare Facility specific reimbursement amount and any applicable outlier payment.

After reviewing the account we have concluded that reimbursement received was inaccurate. WCERA_WORKERS' COMPENSATION EXPECTED REIMBURSEMENT AMOUNT – DRG 482 - $13211.85 (143%) = ERA $18892.95 reimbursement should be $18892.95. Payment received was only $14089.72, thus, according to these calculations; there is pending payment in the amount of $4803.23. We rendered services on good faith based on the information that was exchanged and therefore are also requesting that our claim be reprocessed for additional payment. "

Amount in Dispute: $4,803.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see EOBs. IMO applied the inpatient fee schedule. The charges were reduced accordingly. $14,089.72 was found to be the appropriate reimbursement amount. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 01, 2014 to September 07, 2014	Inpatient Hospital Surgical Services	$4,803.23	$4,083.23

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 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, 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:
   - Charge exceeds fee schedule allowance
   - Reduction is based on the Inpatient Fee Schedule
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 193 – Original payment decision is being maintained. Upon review it was determined that his claim was process properly
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - Previously processed for recommendation

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 482, and that the services were provided at Doctors Hospital at Renaissance. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $13,211.85. This amount multiplied by 143% results in a MAR of $18,892.95.

4. The division concludes that the total allowable reimbursement for the services in dispute is $18,892.95. The respondent issued payment in the amount of $14,089.72. Based upon the documentation submitted, additional reimbursement in the amount of $4,083.23 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 $4,083.23 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		3/26/15
Signature	Medical Fee Dispute Resolution Officer	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.