



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DALLAS COUNTY HOSPITAL

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number

M4-15-2225-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

March 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please be advised that our office represents PARKLAND HOSPITAL in connection with the above referenced mater. Please direct any correspondence or communication regarding this account through our office ...

The attached claim was processed and paid by your company on 11/03/2014. However, the reimbursement issued as significantly below the current Division of Workers' Compensation prescribed fee schedule. The MAR (Maximum Allowable Reimbursement) should be calculated at 143 percent of Medicare's Inpatient Prospective Payment System (IPPS) rate in accordance with 28 TEX. ADMIN CODE §134.404(f) ... The charges incurred in the course of the Claimants' treatment totaled \$22134.41. These charges were billed to BUNCHCARE SOLUTIONS and subsequently a payment was issued on the account which resulted in an underpayment in the amount of \$10256.37."

Amount in Dispute: \$11,405.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR, the bill was sent for additional review. Additional payment in the amount of \$1,621.67 was issued on 4/125/2015. Attached is a copy of the EOR and payment screen."

Response Submitted by: ACE/ESIS

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 23, 2014 to July 25, 2014, Inpatient Hospital Services, \$11,405.26, \$11,405.26

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 acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - W3 – Additional payment made on appeal/reconsideration
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time
 - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
 - 5261 – Letter – Please see additional message codes for information related to this review
 - 169 – Payment adjusted because an alternate benefit has been provided
 - 169 – Reimbursement based on ration. Percentage or formula set by state guidelines
 - P12 – Workers’ Compensation jurisdictional 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?

Findings

The requestor in this dispute originally indicated on its DWC-60 table part III the amount paid by the insurance carrier is \$10,256.37 and the amount in dispute is \$13,026.93. The insurance carrier responded to the dispute on April 17, 2015 stating “Upon receipt of the MDR, the bill was sent for additional review. Additional payment in the amount of \$1,621.67 was issued on 4/15/2015. Attached is a copy of the EOR and payment screen.” The requestor updated the table on its DWC-60 to reflect that additional payment that the carrier has mentioned that was in review. DWC-60 from the requestor indicates amount paid by the insurance carrier is \$11,878.04 and amount in dispute is \$11,405.26.

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 316, and that the services were provided at DALLAS COUNTY HOSPITAL. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$16,282.03. This amount multiplied by 143% results in a MAR of \$23,283.30.
4. The total recommended payment for the services in dispute is \$23,283.30. This amount less the amount previously paid by the insurance carrier of \$11,878.04 leaves an amount due to the requestor of \$11,405.26. The requestor is seeking \$11,405.26. This amount is recommended.

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 \$11,405.26.

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 \$11,405.26 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	5/1/15
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	5/1/15
Signature	Medical Fee Dispute Resolution Manager	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 MFDR 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.