



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MIDLAND MEMORIAL HOSPITAL

Respondent Name

CITY OF MIDLAND

MFDR Tracking Number

M4-15-2445-01

Carrier's Austin Representative

Box Number 04

MFDR Date Received

April 06, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 143% of DRG for inpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet the criteria. Medicare would have allowed this facility \$15,204.58 for DRG 494 at 143%. After their payment of \$14,123.05, a supplemental payment of \$1,081.53 is due."

Amount in Dispute: \$1,062.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of an MDR dated 4/13/15 regarding reimbursement issued for services incurred at Midland Memorial Hospital. On 6/13/14, we received an inpatient bill totaling \$32,895.02. Reimbursement was issued in the amount of \$13,918.33 on 7/15/14. On 8/13/15 we received a reconsideration documenting the Medicare specific reimbursement should have been \$9,876.26 X 143% or \$14,123.05 (copy attached). We were requested to reimburse an additional \$204.72, which we did on 8/22/14.

On 10/28/14 we received another reconsideration documenting the correct Medicare specific reimbursement to be \$15,204.58 and asking for an additional \$1,081.53 (copay attached). On 11/11/14 we maintained our prior reimbursement and denied the reconsideration request.

After further review, we have determined, based on the attached inpatient pricer for Midland Memorial, the correct Medicare specific reimbursement should be \$9889.37 X 143% or total payment of \$14,141.80. We find therefore, reimbursement is due in the amount of \$18.75 plus interest in the amount of \$.49. Payment will be issued on 4/21/15

It is our position correct payment for this bill is \$14,141.80 and that no additional reimbursement would be due."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 17, 2014 through May 20, 2014	Inpatient Hospital Services	\$1,062.25	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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:
 - 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
 - 350 – Bill has been identified as a request for reconsideration or appeal
 - 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
 - P12 – Workers' Compensation jurisdictional fee schedule adjustment
 - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
 - 0468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
 - 0305 – The implant is included in this billing and is reimbursed at the higher percentage calculation

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

The following dispute mentioned above received by the requestor originally filed on part III of the DWC-60 request indicates an amount in dispute of \$1,081.53 and amount paid from the insurance carrier of \$14,123.05. The insurance carrier responded on April 20, 2015 stating "After further review, we have determined, based on the attached inpatient pricer for Midland Memorial, the correct Medicare specific reimbursement should be \$9889.37 X 143% or total payment of \$14,141.80. We find therefore, reimbursement is due in the amount of \$18.75 plus interest in the amount of \$.49. Payment will be issued on 4/21/15." The requestor has provided the division with an updated table which reflects a new amount in dispute of \$1,062.29 and amount paid by the insurance carrier is \$14,142.29.

1. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states:

The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] 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).

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment 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 494. The services were provided at Midland Memorial Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$9,889.37. This amount multiplied by 143% results in a MAR of \$14,141.80.
3. The total recommended payment for the services in dispute is \$14,141.80. This amount less the amount previously paid by the insurance carrier of \$14,142.29 leaves an amount due to the requestor of \$0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established 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 disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

5/29/15

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.