



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

EAST TEXAS MEDICAL CENTER

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-15-3467-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the applicable Texas fee schedule the correct allowable would be per the DRG 513. The allowable for this DRG per Medicare is \$10,041.20, we have also attached the print out for your review from the Medicare pricer program. The correct allowable would be at 143% making the allowable at \$14,449.29. Based on their payment of \$12,028.25, there is an additional of \$2,421.04, still due at this time ...

We respectfully ask that you reprocess this admit at 143% of Medicare allowable per the Texas fee schedule.

Amount in Dispute: \$2,421.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a medical fee dispute concerning service dates 6/19/2014 to 7/10/2014. Requestor billed a total of \$158,645.75. Carrier issued an initial reimbursement of \$12,028.25 on August 11, 2014. Requestor asserted on its DWC-60 that an additional \$2421.04. On July 2, 2015, Carrier issued additional reimbursement in the amount of \$2330.07. Carrier calculated reimbursement on the applicable fee guidelines. A copy of the EOB is attached. No additional reimbursement is owed."

Response Submitted by: Flahive, Ogden & Latson Post Office Drawer 201329 Austin, TX 78720

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 19, 2014 to July 10, 2014, Inpatient Hospital Services, \$2,421.04, \$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:
 - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymt requests, submit a copy of this eor or clear notation that a rec
 - P300 – No reason given
 - Z710 – No reason given

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

1. The requestor initially indicated on its DWC-60 request the amount in dispute is \$2,421.04 and amount paid is \$12,028.25. The requestor then submitted an updated table to medical fee dispute resolution on July 10, 2015 stating “updated TWC60 and EOB attached”, the DWC-60 reflects an amount in dispute of \$90.97 and amount paid of \$14,358.32.
2. 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).

3. 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 513. The services were provided at EAST TEXAS MEDICAL CENTER. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$10,041.20. This amount multiplied by 143% results in a MAR of \$14,358.92.
4. The total allowable reimbursement for the services in dispute is \$14,358.92. This amount less the amount previously paid by the insurance carrier of \$14,358.32. No additional reimbursement is allowed.

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

Date

7/24/15

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.