



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

TX HEALTH SOUTHWEST

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-15-4032-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health Southwest to audit their Workers Compensation claims. We have found in this audit they have not paid correctly according to the Hospital Facility Fee Guideline for inpatient claims. Pursuant to Rule 134.404, reimbursement, "regardless of billed charges" (quoted from section (e)), is to be paid at 143% of the Medicare rate unless implants were requested to be carved out of the reimbursement amount at billing. NO such request was made; therefore, the allowable should be 143% of the DRG rate under Medicare pursuant to section (f) of the rule."

Amount in Dispute: \$19.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. Carrier contends that it properly processed reimbursement. 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."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2014 to December 08, 2014	Inpatient Hospital Services	\$19.49	\$19.49

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:
 - P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
 - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

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. 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 603. The services were provided at Texas Health Southwest FW. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$5,724.41. This amount multiplied by 143% results in a MAR of \$8,185.91.
3. The total recommended payment for the services in dispute is \$8,185.91. This amount less the amount previously paid by the insurance carrier of \$8,166.42 leaves an amount due to the requestor of \$19.49. The requestor is seeking \$19.49. 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 \$19.49.

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 \$19.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

9/11/15

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.