



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

Surgery Specialty Hospitals

Respondent Name

Liberty Mutual Fire Insurance

MFDR Tracking Number

M4-16-0064-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

September 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Provider submitted a correct bill to the Carrier in which the Carrier denied the claim yet again. On August 03, 2015, the Provider sent the Carrier a Request for Reconsideration noting that the Carrier failed to reimburse the Provider pursuant to the appropriate sections of the fee guideline applicable, specifically, 28 Tex Admin Code section §134.404(f)(1)(A)."

Amount in Dispute: \$11,254.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have received the medical dispute filed by (requestor) for services rendered to (injured worker) for the 10/23/2014 date(s) of service. The bill and documentation attached to the medical dispute have been re-reviewed. CPT 27486 is a Status Indicator C (Inpatient Only) procedure. We received a corrected bill on 08/10/15 from bill type 0131 to 011, but without R&B. Our position remains unchanged."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 23, 2014, Inpatient Hospital Services, \$11,254.29, \$11,254.29

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. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care

providers.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - X936 – CPT or HCPC is required to determine if services are payable
 - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
 - U415 – Procedure code not reimbursable in an outpatient setting per state or Medicare guidelines.
 - U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

Issues

1. Is the respondent's position statement supported?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent in their position states, "We received a correct bill on 08/10/15 from bill 0131 to 0111, but without R&B." 28 Texas Administrative Code 133.20 (g) states, "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."
 - a. First claim with bill type 131 submitted on 11/20/2014
 - b. Explanation of benefits dates January 23, 2015 showing procedures not payable in outpatient setting
 - c. Corrected Claim submitted on July 10, 2015 with bill type 111
 - d. Medicare Benefit Policy Manual, Chapter 1, Section 10, Covered Inpatient Hospital Services Covered Under Part A, "An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."

Based on the above the requestor did submit a corrected bill for the services that are considered "inpatient" by the Medicare definition and even though the patient was discharged and did not stay overnight, the services can still be considered inpatient. Therefore the Division finds the respondent's position is not supported and the services in dispute will be reviewed per applicable rules and fee guidelines.

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 489. The services were provided at Surgery Specialty Hospitals of America. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$7,870.27. This amount multiplied by 143% results in a MAR of \$11,254.29.
4. The total allowable reimbursement for the services in dispute is \$11,254.49. The amount previously paid by the insurance carrier is \$0.00. The requestor is seeking additional reimbursement in the amount of \$11,254.29. 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 \$11,254.49.

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 \$11,254.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October , 2015
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 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.