



# 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**

SOUTH TEXAS HEALTH SYSTEM

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-16-0549-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

November 02, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "HRA has been hired by South Texas Health System to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine to be the correct amount for this inpatient surgery per the Texas fee schedule in effect as of 2008.

Per the applicable Texas fee schedule the correct allowable would be per the DRG 520. The allowable for this DRG per Medicare is \$8,858.45, 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 \$7,12,66.7.58Based on their payment of \$12,652.63 there is an additional of \$14.98 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:** \$14.98

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute of 2/10/2015 to 2/12/2015.The requestor argues an additional \$14.95 is due based on IPPS Pricer 2015.3 PSF 10/14.

Texas Mutual used the current Pricer in effect to adjudicate the Medicare base payment, ie. 2015.4 PSF 7/15, which is \$8,847.99. This amount multiplied by 1.43 is \$12.652.63, the amount Texas Mutual paid."

**Response Submitted by:** Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 10, 2015 to February 12, 2015	Inpatient Hospital Services	\$14.98	\$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:
  - CAC-P12 – Workers Compensation jurisdictional fee schedule adjustment
  - CAC-W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal
  - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
  - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
  - 217 – The value of this procedure is included in the value of another procedure performed on this date
  - 350 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal
  - 420 – Supplemental payment
  - 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
  - 891 – No additional payment after reconsideration
  - CAC-18 – Exact duplicate claim service
  - 724 – No additional payment after a reconsideration of services
  - 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(H)

### **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).

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 520. The services were provided at SOUTH TEXAS HEALTH SYSTEM. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$8,847.99. This amount multiplied by 143% results in a MAR of \$12,652.63.

2. The total allowable reimbursement for the services in dispute is \$12,652.63. This amount less the amount previously paid by the insurance carrier of \$12,652.63 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

### **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**

_____	_____	12/04/15
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.**