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
Dallas County Hospital

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-16-0778-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
November 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was processed and paid by your company on 02/13/2015. However, the reimbursement issued was significantly below the current Division of Workers' Compensation prescribed fee schedule."

Amount in Dispute: $21,791.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier maintains their denial of the remaining charges as no preauthorization was obtained for dates of service 11/13/14 to 11/24/14. Therefore, those service dates were excluded from the IPPS Reimbursement Calculations."

Response Submitted by: Broadspire, P.O. Box 14351, Lexington, KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2014 through October 24, 2014	Inpatient Hospital Services	$21,791.28	$21,791.28
October 25, 2014 through November 17, 2014	Inpatient Hospital Services	Included in the above	
November 18 – 24, 2014	Inpatient Hospital Services	Included in the above	

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 §134.600 sets out the guidelines for prospective and concurrent review of healthcare.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service
   - A31 – Services reviewed by a nurse
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guidelines
   - 305 – The implant is included in the billing and is reimbursed at the higher percentage calculation
   - 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
   - A47 – Treatment not certified by utilization review
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - D00 – Based on further review, no additional allowance is warranted
   - P13 – Payment reduced or denied based on Workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable

Issues

1. What is the date span of the services in dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the applicable rule for determining reimbursement of the disputed services?
4. What is the recommended payment for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are three inpatient hospital stays with different admission and discharge dates. Review of the submitted medical claims find the following dates of service are in dispute;
   - Admission date of September 30, 2014 – Discharge date of October 24, 2014, with billed amount of $205,948.85
   - Admission date of October 25, 2014 – Discharge date of November 17, 2014, with billed amount of $102.758.45
   - Admission date of October 18, 2014 – Discharge date of November 24, 2014, with billed amount of $22,734.29
   - The total billed charges = $331,441.59

   Review of the submitted explanation of benefits finds all dates of service were considered on an explanation of benefits with "Post date" of February 6, 2015, from which a payment of $81,570.79 was made.
2. The insurance carrier reduced the payment for the disputed services for the admission from September 30, 2014 through October 25, 2014, with claim adjustment reason code 468 – "Reimbursement is based on the medical hospital inpatient prospective payment system methodology and P12 – "Workers' compensation jurisdictional fee schedule adjustment." 28 Texas Administrative Code §§134.404 (f) states, "The reimbursement calculation used for establishing the MAR 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. " Based on the remark codes used by the Carrier, the appropriate Medicare Payment System or Inpatient Prospective Payment System (IPPS) was used. The calculation of the Maximum Allowable Reimbursement (MAR) will be calculated in a separate paragraph.

For the admission from October 25, 2014 through November 17, 2014, the carrier calculated the fee with above mentioned remark codes 468, and P12. However beginning with date of service November 13, 2014, the carrier utilized remark code A47 – "Treatment not certified by utilization review."

28 Texas Administrative Code §134.600(p) states, "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;"
Review of the submitted documentation finds insufficient information to indicate denied dates were prior authorized. The carrier's denial for date of service November 17 – 24, 2014 is supported. No additional payment can be recommended.

For the admission from November 18 – 24, 2014, the carrier denied the disputed service as A47 – "Treatment not certified by utilization review."

28 Texas Administrative Code §134.600 (c) states,

The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:
(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;
(C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or
(D) when ordered by the commissioner;

Review of the submitted documentation finds insufficient information to indicate that any of the above requirements for the dates in dispute were prior authorized. The carrier's denial for date of service November 17 – 24, 2014 is supported. No additional payment can be recommended.

3. 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).

4. 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 907. The services were provided at Parkland Health and Hospital System. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $135.001.76 (Admission from 9-30 to 10 -24 total $89,918.58, Admission from 10-25 to 11-12/2014 total $45,083.18). This amount multiplied by 143% results in a MAR of $193,052.52.

5. The requestor is seeking $21,791.28. 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 $21,791.28.

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 $21,791.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		January 12, 2016
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.