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
WEST HOUSTON MEDICAL CENTER

Respondent Name
ALIEF ISD

MFDR Tracking Number
M4-16-1706-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
February 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should have been paid in accordance with 28 T.A.C. § 134.403 . . . This is the formula to be used absent certain circumstances that do not apply to the present case. Using this formula, the hospital would have been entitled to $8,992.53 in reimbursement. The Carrier only paid $7,667.33. Therefore, the Hospital contends an additional $1,325.20 remains owed."

Amount in Dispute: $1,325.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2015 to May 19, 2015	Inpatient Hospital Services	$1,325.20	$1,325.20

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 Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged February 29, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not respond. Accordingly, this decision is based on the information available at the time of review.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 169 – REIMBURSEMENT BASED ON RATIO PERCENTAGE OR FORMULA SET BY STATE GUIDELINES.
   - 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 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards the facility medical services of an inpatient acute care hospital with reimbursement subject to the provisions of 28 Texas Administrative Code §134.404(f), which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule.

   Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

2. Per Rule §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. The DRG code assigned to the services in dispute is 087. The services were provided at West Houston Medical Center. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $6,480.95. This amount multiplied by 143% results in a MAR of $9,267.76.

3. The total recommended payment for the services in dispute is $9,267.76. The insurance carrier has paid $7,667.33. The requestor is seeking $1,325.20. 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 $1,325.20.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,325.20, plus applicable accrued interest per 28 Texas Administrative Code §134.13, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 7, 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.