



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

Liberty Insurance Corp

MFDR Tracking Number

M4-16-3027-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

June 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the applicable Texas fee schedule the correct allowable would be per the DRG 520. The allowable for this DRG per Medicare is \$9,097.63, 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 \$13,009.25. Based on their payment of \$11,360.08, there is an additional of \$1,379.17, still due at this time."

Amount in Dispute: \$1,379.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were previously paid for billed DRG 520 at 143% Medicare rate per Texas Fee Schedule, \$12,431.20."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5 – 9, 2016	Inpatient Hospital Services	\$1,379.17	\$583.16

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
 - W3 – Additional payment made on appeal/reconsideration

- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment

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 regards the facility medical services of an inpatient acute care hospital with reimbursement subject to the provisions of Code 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 §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>. 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 \$9,100.95. This amount multiplied by 143% results in a MAR of \$13,014.36.
3. The total recommended payment for the services in dispute is \$13,014.36. The insurance carrier has paid \$12,431.20. The amount due to the requestor is \$583.16. 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 \$583.16.

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 \$583.16, 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

June , 2016
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.