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
ST DAVIDS MEDICAL CENTER

Respondent Name
TEXAS MUNICIPAL LEAGUE INTERGOVERNMENTAL RISK POOL

MFDR Tracking Number
M4-16-3648-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 10, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the Hospital believes a fair and reasonable reimbursement amount . . . is 100% of billed charges. . . . the Hospital is prepared to accept 40% of charges . . . as full reimbursement . . . Over the past year, the Hospital and its affiliated facilities have been paid up to 100% of billed charges for rehabilitation services from non-contracted payers. The 40% of billed charges sought by the Hospital here is well within the fair and reasonable parameters set by the Texas Administrative Code."

Amount in Dispute: $44,875.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TMLIRP calculated a fair and reasonable reimbursement rate under a comparison of the Medicare DRG rate X 143% and the Medicare PC Pricer of Inpatient Rehab Facility Rate."

Response Submitted by: Flahive, Ogden & Latson, Attorneys At Law, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 21, 2016 to March 22, 2016	Inpatient Hospital Services	$44,875.16	$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 division's *Hospital Facility Fee Guideline—Inpatient*.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fe
   - 217 – Based on payer reasonable and customary

Issues

1. Is there a medical fee guideline applicable to the disputed services?
2. What is the rule for determining reimbursement of the services in dispute?
3. What is the maximum allowable reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards inpatient rehabilitation services provided to an injured employee by an acute care hospital.

   Per Rule §134.404(a)(1), the division's *Hospital Facility Fee Guideline—Inpatient*, Title 28 Texas Administrative Code Chapter 134.404, is applicable to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008.

   Rule §134.404(b)(2)defines "acute care hospital" as "a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma."

   Review of licensing information held by the Texas Department of State Health Services finds that the health care provider, St. David's Medical Center, is a hospital appropriately licensed to provide such care meeting the requirements of the definition in the rule. Review of the submitted information finds that the provider is also certified with Medicare to provide such care, and has a valid Medicare provider number for billing as an inpatient hospital. The "bill type" code on the medical bill indicates an inpatient hospital facility claim.

   Accordingly, the division concludes the health care provider is an inpatient acute care hospital (as opposed to a long-term acute care hospital—LTAC—or rehabilitation facility), and as the services were rendered after March 1, 2008, the applicable fee guideline is the division's *Hospital Facility Fee Guideline—Inpatient*.

2. Reimbursement for Inpatient hospital facility medical services provided to an injured employee is 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. Information regarding IPPS reimbursement formulas and factors is available from http://www.cms.gov.

   Rule §134.404(f)(1)(A) requires that, for these disputed services, the Medicare facility specific amount, including any outlier payment, be multiplied by 143 percent.

3. Review of the submitted medical bill and supporting documentation finds that the DRG code assigned to the disputed services is 945. The services were provided at St. David's Medical Center located at 919 E. 32nd Street, Austin, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the division determines that the Medicare facility specific amount is $23,435.80. This amount multiplied by 143% results in a MAR of $33,513.19.

4. The total recommended payment for the services in dispute is $33,513.19. The insurance carrier has paid $68,714.73, leaving no additional reimbursement due to the requestor.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

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 on 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 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	February 10, 2017
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 Rule §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. **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.