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
MHHS Southwest Hospital

Respondent Name
Travelers Casualty Ins Co of America

MFDR Tracking Number
M4-18-0683-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
November 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $38,698.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider bases their contention on a DRG 470 IPPS reimbursement base rate of $17,773.21. The Carrier disagrees that this is the appropriate base rate, as the Carrier has calculated the DRG470 base rate as $13,861.54. When multiplied by the DWC conversion factor of 143%, reimbursement comes to $19,822.00, which is a $749.18 overpayment by the Carrier. The Carrier believes no additional reimbursement is due."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 15 – 29, 2017	Inpatient Hospital Services	$38,698.62	$5,792.04

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:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for inpatient hospital services in the amount of $38,698.62. The submitted medical bill indicates a "from" date of June 15, 2017 through June 29, 2017. The submitted medical documents indicate the inpatient stay was from June 27, 2017 through June 29, 2017. These dates were entered into the FY 2017 Inpatient Prospective Payment (IPPS) "PC Pricer" found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

   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. 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.

   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).

   Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 470. The services were provided at MHHS Southwest Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $18,435.82. This amount multiplied by 143% results in a MAR of $26,363.22.

2. The total recommended payment for the services in dispute is $26,363.22. The insurance carrier has paid $20,571.18. The amount due to the requestor is $5,792.04. 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 $5,792.04.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $5,792.04, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		January 12, 2018
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.