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
Memorial Hermann Hospital

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-18-1274-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our review of the applicable medical and surgical fee schedule does not reveal justification for reductions take on this claim."

Amount in Dispute: $12,703.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money."

Response Submitted by: ESIS, P.O. Box 6563, Scranton, PA 18505-6563

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2017 through April 14, 2017	Inpatient Hospital Services	$12,703.75	$12,703.75

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:
   - 18 – Duplicate claim/service
   - 131 – Claim specific negotiated discount
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for inpatient hospital services rendered from March 4, 2017 through April 14, 2017 in the amount of $12.703.75.

   The insurance carrier reduced payment for the disputed services with claim adjustment reason code P12 - "Workers compensation jurisdictional fee schedule adjustment" and 131 – "Claim specific negotiated discount."

   28 Texas Administrative Code §134.404 (e) and (f) state in pertinent part,

   > (e) Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   >
   > > (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   > >
   > > (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.
   >
   > (f) 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 information found insufficient evidence of a contract or negotiated amount or that the facility requested separate reimbursement of the implants. Therefore, the insurance carrier's reduction reasons are not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

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 957. The services were provided at MHHS Hermann Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $159,150.86. This amount multiplied by 143% results in a MAR of $227,585.73.

3. The total recommended payment for the services in dispute is $227,585.73. Evidence of an insurance carrier payment of $171,882.93 was submitted. The requestor is seeking $12,703.75. 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 $12,703.75.

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 $12,703.75 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		January 25, 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.