Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX HEALTH FORT WORTH

Respondent Name
SENTINEL INSURANCE COMPANY LTD

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-18-3174-01

MFDR Date Received
May 01, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has previously been denied by the payer, Hartford as not additional allowance allowed. This claim was placed with EnableComp by the client, Texas Health Harris Methodist Hospital Fort Worth, on 05/03/2017. Per CMS Inpatient PC Pricer for 2017, DRG 488 reimbursement rate is $11,287.66…"

Amount in Dispute: $4,839.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Fee Schedule & Guidelines, Rule 134.404. Attached please find our review of the disputed services and breakdown of payment."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 19, 2017 to April 29, 2017	Inpatient Hospital Surgical Services	$4,839.96	$4,695.05

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 12, 2017
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is a supplied using remittance advice remarks codes whenever appropriate
   - 266 – Please submit an itemized billing to ensure accurate processing

- 295 – Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing
- DOCU – Reimbursement determination pending receipt of operative Report and/or treatment notes

Explanation of benefits dated September 27, 2017

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- W3 – Additional payment made on appeal/reconsideration
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment
- 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup
- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment ad not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment

Issues

1. Which reimbursement calculation applies to the services in dispute?
2. What is the maximum allowable reimbursement for the services in dispute?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. §134.404(f) states that "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."

   The division establishes the total Medicare facility specific amount in this case using the *Medicare Inpatient PPS PC Pricer* as a tool. The *Medicare Inpatient PPS Pricer* efficiently identifies facility specific payment factors and adjustment. The pricer is found at www.cms.gov.

   The following illustrates the division's calculation of the total Medicare facility specific amount:

TOT DRG AMT:	Add back VBP CR *(not applicable due to conflict with Texas Labor Code)*	Add Cost Outlier *(applicable)*	Total Medicare Facility Specific Amount
$11,184.06	+ $2.26	+ $0.00	$11,186.32

   Note that a claim reduction identified as "VBP CR" on the *Medicare Inpatient PPS Pricer* was added back into the total DRG amount for this admission. "VBP CR" stands for Value-Based Purchasing (VBP) claim reduction (CR) which in Medicare is used to fund the Medicare VPB program. Medicare's VBP program was implemented to monitor and improve quality of care provided at inpatient hospitals participating in the Medicare system. Consequently, the Medicare VBP program conflicts with existing Texas Labor Code (TLC) sections 413.0511 and 413.0512 which provide for the review and monitoring of the quality of health care provided in the Texas workers' compensation system. The fee rule for inpatient hospital services contains a conflict provision which explains that the Texas Labor Code in such instances takes precedence:

   > 28 TAC §134.404 (d)(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

For this reason, the VBP CR amount does not apply. The VBP claim reduction amount was therefore added back in because it does not apply to inpatient hospital services provided in the Texas Workers' Compensation system.

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

2. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 488, and that the services were provided at TX Health Fort Worth. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of 11,186.32. This amount multiplied by 143% results in a MAR of $15,996.44.
3. The total allowable reimbursement for the services in dispute is $15,996.44. This amount less the amount previously paid by the insurance carrier of $11,301.39 leaves an amount due to the requestor of $4,695.05. This amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,695.05 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	6/1/2018 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 MDR 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.