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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Fort Worth

Respondent Name
Tarrant County

MFDR Tracking Number
M4-18-3516-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
May 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The allowable for this DRG per the Medicare is $7,313.41."

Amount in Dispute: $2,209.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Careworks stands on the original audit results and subsequent reconsideration denials."

Response Submitted by: Careworks Managed Care Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5 -7 , 2017	Inpatient Hospital Services	$2,209.42	$0.00

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 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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated

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. The requestor is seeking additional reimbursement for an inpatient hospital stay from June 5 to June 7, 2017 in the amount of $2,209.42. The requestor made a payment with claim adjustment code P12 – "Workers' compensation jurisdictional fee schedule adjustment."

   28 Texas Administrative Code §134.404(f), states,

   > The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] 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 medical bill, specifically the information in box 17, indicates "62" post-acute transfer to a facility excluded from IPPS. When this information is entered into the Medicare Inpatient Prospective Payment (IPPS) payment system found at http://www.cms.gov, indicating this was a post-acute transfer the following information is received.

2. The DRG code assigned to the services in dispute is 543. The services were provided at Texas Health Fort Worth. Based on the submitted DRG code, the post-acute transfer reduction explained at, Medicare Claims Processing Manual, Chapter 3, Section 402.4 (C), the service location, and other bill-specific information, the Medicare facility specific amount is $5,793.53. This amount multiplied by 143% results in a MAR of $8,284.75.
3. The total recommended payment for the services in dispute is $8,284.75. The requestor paid $8,284.75. No additional payment is recommended.

Conclusion

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 upon 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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 15, 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 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.