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
MHHS SOUTHWEST HOSPITAL

Respondent Name
MID-CENTURY INSURANCE COMPANY

MFDR Tracking Number
M4-18-3661-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
May 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the claim was underpaid under Texas Workers Compensation Fee Schedule."

Amount in Dispute: $13,933.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 7, 2017 to November 9, 2017	Inpatient Hospital Services	$13,933.30	$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 hospital facility fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 105 – Additional information needed to review charges
   - 16 – Svc lacks info needed or has billing error(s)
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adj
   - W3 – Appeal/Reconsideration

Issue

Is the requestor entitled to additional payment?

Findings

This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors published in the Federal Register, with modifications set out in the rule. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

Separate reimbursement for implantables was not requested; accordingly, Rule §134.404(f)(1)(A) requires that for these services the Medicare facility specific amount, including any outlier payment, be multiplied by 143%.

The division calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is also freely available from www.cms.gov.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 872. The service location is Houston, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $8,091.27. This amount multiplied by 143% results in a MAR of $11,570.52.

The total recommended payment for the services is $11,570.52. The insurance carrier paid $11,570.20. Additional payment is not 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	January 11, 2019
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.

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 form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.