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
SURGERY SPECIALTY HOSPITAL SE

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-18-3808-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 5, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is unclear why this was sent to a review company to review implants because the Provider did not request that the implantables be paid separately, the Carrier should have reimbursed Provider pursuant to section §134.404(f)(1)(A)."

Amount in Dispute: $2,366.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to a review by ForeSight Medical, no reimbursement is due for the implants. Payment was issued in accordance with the inpatient hospital fee schedule."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 11, 2017 to September 13, 2017	Inpatient Hospital Facility Services	$2,366.66	$2,366.66

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:
   - 1 – Workers' compensation jurisdictional fee schedule adjustment.
   - 2 – Your billing has been paid in accordance with the Inpatient Hospital Fee Schedule
   - 3 – This implant charge was reimbursed according to review by ForeSight medical.

Issues

1. What is the recommended payment amount for the services in dispute?
2. Is the requestor entitled to additional payment?

Findings

1. This dispute regards inpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.404(f), 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, as published annually in the Federal Register, with modifications set forth in the rules. 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 freely available from www.cms.gov.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 473. The service location is Surgery Specialty Hospital in Pasadena, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $43,143.82. This amount multiplied by 143% results in a MAR of $61,695.66.

2. The total recommended payment for the services in dispute is $61,695.66. The insurance carrier paid $59,329. The amount due to the requestor is $2,366.66. This amount is recommended.

Conclusion

The requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,366.66.

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 $2,366.66, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 20, 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.

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 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.