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
TEXAS HEALTH OF PLANO

Respondent Name
CONTINENTAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-1920-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
December 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Incorrect DRG Rate: Please see attached calculation of Inpatient Pricer and reprocess and pay remaining $46.39."

Amount in Dispute: $46.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Bill was audited and the Explanation of Review resulted in the recommended allowance of $15,466.71."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 20, 2018 to August 23, 2018	Inpatient Hospital Services	$46.39	$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:
   - 94 – Processed in Excess of charges.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

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 www.cms.gov.

Separate reimbursement for implants 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.

The requestor asserts, "Incorrect DRG Rate: Please see attached calculation of Inpatient Pricer…"

The division notes that, based on the submitted information, the requestor used an outdated version of Medicare's Inpatient Pricer software to calculate the reimbursement. The requestor used the initial release of the 2018 Inpatient Pricer, Calculator Version C18.1. However, Medicare has released a revised version of the 2018 Inpatient Pricer, Calculator Version C18.2, which will be used to calculate the payment in this review.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 482. The service location is Plano, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $10,815.88. This amount multiplied by 143% results in a MAR of $15,466.71.

The total recommended payment for the services in dispute is $15,466.71. The insurance carrier paid $15,466.71. The amount due to the requestor is $0.00. 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 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 18, 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.