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
PLANO SURGICAL HOSPITAL

Respondent Name
TRAVELERS CASUALTY & SURETY COMPANY

MFDR Tracking Number
M4-19-3763-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
April 10, 2019

Response Submitted By
Travelers

REQUESTOR'S POSITION SUMMARY

"The bill should have paid: 109483.80 x 143% = 156561.83 … It paid 101584.28 I am requesting a payment for the difference which is 54977.55."

RESPONDENT'S POSITION SUMMARY

"the Provider was properly reimbursed per the Medicare edits and the Division's Maximum Allowable Reimbursement."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 16, 2018 to May 20, 2018	Inpatient Hospital Services	$54,977.55	$0.00

AUTHORITY

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

Background

1. 28 Texas Administrative Code §134.404 sets out the hospital facility fee guideline for inpatient services.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P18 – PROCEDURE IS NOT LISTED IN THE JURISDICTION FEE SCHEDULE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 5089 – Review of the submitted documentation does not support the classification of stop-loss or outlier for the specific diagnosis or treatment rendered. Therefore reimbursement was based on standard rates.
   - 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 247 – A payment or denial has already been recommended for this service
   - DUPL – These services have already been considered for reimbursement.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 1001 - Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - DPAY – Payment for services were repriced in accordance with state DRG guidelines.

Issues

Did the requestor support that additional payment is due?

Findings

This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404(f), which requires 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*," with minimal modifications as specified in the guideline. Medicare IPPS formulas and factors are available from http://www.cms.gov.

Review of the submitted information finds the healthcare provider did not provide sufficient information to calculate a reimbursement using Medicare IPPS formulas and factors. The health care provider does not appear to have a Medicare provider number. In support of the requested payment, the requestor submitted a copy of a Medicare IPPS pricer printout calculating reimbursement using Medicare provider number 100321. This is not the Medicare provider number for this facility. 100321 appears to be the facility's Texas medical license number.

Medicare records show that Medicare provider number 100321 is not assigned to Plano Surgical Hospital, but rather to St. Vincent's Medical Center - Clay County, Florida. The health care provider's calculation of the payment due is not based on the Medicare factors applicable to the disputing hospital and thus does not represent the Medicare facility specific amount for the requesting hospital — which is what is required by Rule §134.404(f).

The requestor has the burden at MFDR to support its request for additional reimbursement by a preponderance of the evidence. The division concludes the requestor failed to support that additional payment is due. Consequently, additional reimbursement cannot be recommended.

Conclusion

The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered. For the reasons stated above, the division finds the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 10, 2019
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	May 10, 2019
Signature	Director of Medical Fee Dispute Resolution	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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.