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 Dallas

Respondent Name
American Casualty Co of Reading PA

MFDR Tracking Number
M4-19-3841-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
April 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the applicable Texas fee schedule the correct allowable would be per the DRG 329. The allowable for this DRG per the Medicare is $31,902.45, we have also attached the print out for your review from the Medicare pricer program. The correct allowable would be at 143%, making the allowable at $45,620.50. Based on their payment of $30,180.57, there is an additional allowance of $15,439.93 still due at this time."

Amount in Dispute: $15,439.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has determined that no additional reimbursement is owed."

Response Submitted by: Brian J Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20 – 26, 2018	Inpatient Hospital Services	$15,439.93	$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:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

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 rendered from April 20, 2018 through April 26, 2018. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states that:

   > 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.

   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

   However, review of the submitted medical bill found in box 17 of the UB04 the status indicator of "06" that per the Medicare claims processing manual, Chapter 3, at www.cms.gov, has the following meaning;

   > *C. - Postacute Care Transfers*
   > *For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in 42 CFR 412.4(c), to one of the qualifying Postacute MS-DRGs referenced in paragraph (D) of this section and the discharge is made under any of the following circumstances:*
   > - *To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (Patient Status Code 06).*

   The application of this information in the IPPS Pricer found a total payment of $21,029.26.

   Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 329. The services were provided at Texas Health Dallas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $21, 029.26. This amount multiplied by 143% results in a MAR of $30,071.84.

2. The total recommended payment for the services in dispute is $30,071.84. The insurance carrier made a payment of $30,180.57 leaving an amount due to the requestor of $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 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

		May 16, 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 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.