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 Allen

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-19-5054-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
July 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have verified there is no PPO reduction, and implants are not carved out in box 80. We have submitted this claim for a reconsideration and the carrier denied our request."

Amount in Dispute: $373.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 23, 2018	Inpatient Hospital	$323.22	$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 acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking $373.22 for inpatient hospital services the insurance carrier reduced based on the workers' compensation feel schedule.

   28 Texas Administrative Code 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%.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 455. The service location is Allen, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $31,302.00. This amount multiplied by 143% results in a MAR of $44,761.86.

2. The total recommended payment for the services in dispute is $44,761.85. The insurance carrier has paid $44,761.86. The amount due to the requestor is $0.00.

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

		August 23, 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 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.