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
PHYSICIANS SURGICAL HOSPITAL

Respondent Name
EAST TX EDUCATIONAL INSURANCE ASSOCIATION

MFDR Tracking Number
M4-19-5301-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 26, 2019

Response Submitted By
CAS, Claims Administrative Services, Inc.

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for consideration in this review.

RESPONDENT'S POSITION SUMMARY

"It is our position that payment issued has been correct and no additional reimbursement is due."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 27, 2019 to May 31, 2019	Inpatient Hospital Services	$255.40	$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 (DWC).

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:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology.
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Findings

This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, at 28 Texas Administrative Code §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 with modifications set out in the rule. Medicare IPPS formulas and factors are available from 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%.

DWC 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.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 482. The service location is Amarillo, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $8,808.66. This amount multiplied by 143% results in a MAR of $12,596.38.

The total recommended payment for the disputed services is $12,596.38. The insurance carrier paid $12,596.38. The amount due is $0.00. No additional payment is recommended.

Conclusion

For the reasons above, 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 13, 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 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.