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 Flower Mound

Respondent Name
Employers Mutual Casualty Co

MFDR Tracking Number
M4-19-5303-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code.

Amount in Dispute: $41.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains that its reimbursement calculation is correct."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18 – 23, 2019	Inpatient Hospital Services	$41.19	$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:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 193 – Original payment decision is being maintained

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. This dispute relates to facility medical services provided in an inpatient acute care hospital. Reimbursement is subject to the provisions of 28 TAC §134.404(f)(1), which states in pertinent part,

   > 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. The MAR is calculated based on 134.404 (f)(1)(A) below.

2. The facility specific calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted medical bill finds that the submitted DRG code was 872.

   The services were provided at Physician's Surgical Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $6,971.87. This amount multiplied by 143% results in a MAR of $9,969.77.

3. The total recommended payment for the services in dispute is $9,969.77. This amount less the amount previously paid by the insurance carrier of $9,969.77 leaves an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

For the reasons stated above, DWC 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

Signature	Medical Fee Dispute Resolution Officer	September 24, 2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 DWC. **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.