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
St Joseph Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-1213-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 14, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per UB-04 only date of service 08/13/2019 is being billed. Also, on medical records (page 71) authorization #15861480 was given for 2 days and was good from 07/19/2019 til 09/30/19. Therefore, preauthorization denial is invalid."

Amount in Dispute: $23,367.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Acute inpatient services are paid per preauthorized length of stay of the compensable DRG. Audit staff denied the bill due to length of stay exceeding preauthorization. The requestor and/or facility did not fully comply with Texas Administrative code Rule 134.600(f)(p) and Rule 134.600(p)(1). No additional payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 13 – 16, 2019	Inpatient Hospital Services	$23,367.01	$23,367.01

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. 28 Texas Administrative Code §134.600 sets out the requirements for prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 198 – Precertification/authorization exceeded
   - 193 – Original payment decision is being maintained

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of inpatient hospital services rendered from August 13 – 16, 2019. The insurance carrier denied the services as the authorized length of stay was exceeded.

   Review of the submitted documentation found the insurance carrier authorized the inpatient stay "2 Days Cervical Laminectomy at Bilateral C3-C7."

   28 TAC §134.600 (p) (1) states non-emergency health care requiring preauthorization includes inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.

   Based on the above, payment for the authorized 2 days of service will be paid per applicable fee guideline.

2. 28 Texas Administrative Code §134.404(f) 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.

   Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov.

   The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent unless a request for separate reimbursement of implants is requested.

   No documentation was found to support that the facility requested separate reimbursement for implants. The fee calculation per the submitted documentation finds that the DRG code assigned to the services in dispute is 519. The services were provided at St Joseph Medical Center.

   Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $17,159.07. This amount multiplied by 143% results in a MAR of $24,537.47.

3. The total recommended payment for the services in dispute is $24,537.47. The requestor is seeking $23,367.01. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $23,367.01.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $23,367.01, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		February 7, 2020
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 DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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