TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
UT HEALTH TYLER

**Respondent Name**
ARCH INSURANCE COMPANY

**MFDR Tracking Number**
M4-19-5033-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
July 30, 2019

**Response Submitted By**
Flahive, Odgen & Latson, Attorneys at Law, PC

## *REQUESTOR'S POSITION SUMMARY*

"Incorrect DRG Rate."

## *RESPONDENT'S POSITION SUMMARY*

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

## *SUMMARY OF DISPUTE*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| March 18, 2019 to March 22, 2019 | Inpatient Hospital Services | $239.68 | $239.68 |

## *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.

### 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:
   - 00137 – (97) The benefit for this service is included in the payment/allowance for another service/procedure hat has already been adjudicated.
   - 00663 – Reimbursement has been calculated according to State Fee Schedule Guidelines.
   - 00134 – (94) Processed in excess of charges.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – Request for reconsideration.
   - ZD86 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### Issues

Is the requestor entitled to additional payment?

## Findings

This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, Rule §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 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%.

The division 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.

Note: the claim reductions identified by Medicare's *Inpatient PPS PC Pricer* as "VBP adjustment," "Readmissions adjustment," and "HAC adjustment" were removed (the credits were added back in) in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program, Hospital Readmissions Reduction Program (HRRP), and Hospital-Acquired Condition (HAC) Reduction Program are performance-based initiatives to improve quality of care in the Medicare system. However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system.

Rule §134.404(d)(1) requires that "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program."

Consequently, VBP adjustments, Readmissions adjustments and HAC adjustments do not apply and are not considered in determining the facility reimbursement in the Texas workers' compensation system.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 460. The service location is Tyler, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $23,706.81. This amount multiplied by 143% results in a MAR of $33,900.74.

The total recommended payment for the disputed services is $33,900.74. The insurance carrier paid $32,952.27. The requestor is seeking $239.68. This amount is recommended.

## Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $239.68.

## *ORDER*

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $239.68, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

| | Grayson Richardson | 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.

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

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.