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
UT HEALTH TYLER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-20-0351-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 8, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Incorrect DRG Rate Adjustments… This inpatient bill has been underpaid."

RESPONDENT'S POSITION SUMMARY

"Texas Mutual processed the inpatient bill in accordance with Rule 134.404 Hospital Facility Fee Guideline Inpatient."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 5, 2019 to June 12, 2019	Inpatient Hospital Services	$161.26	$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) in Title 28, Part 2 of the Texas Administrative Code.

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:
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 305 – THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
   - 468 – REIMBURSEMENT IS BASED ON THE MEDICAL HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM METHODOLOGY.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

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%.

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.

Note: the "VBP adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative 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 Labor Code provisions and division rules take precedence over conflicting CMS provisions for administering Medicare. Consequently, VBP adjustments are not considered in determining the facility reimbursement.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 472. The service location is Tyler, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $17,101.03. This amount multiplied by 143% results in a MAR of $24,454.47.

The total allowable reimbursement for the services in dispute is $24,454.47. This amount less the amount previously paid by the insurance carrier of $24,581.66 leaves an amount due to the requestor of $0.00. Consequently, no additional reimbursement can be recommended..

Conclusion

For the reasons above, the requestor did not establish that additional payment is due. 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	December 6, 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.