



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 ROCKWALL

Respondent Name

Technology Insurance Co.

MFDR Tracking Number

M4-20-0741-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

November 20, 2019

Response Submitted By

Downs Stanford, P.C.

REQUESTOR'S POSITION SUMMARY

"This claim was underpaid per the DRG rate."

RESPONDENT'S POSITION SUMMARY

"The hospital admission was paid pursuant to the IPPS amount multiplied by the state markup, 143%."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 29, 2019 to February 10, 2019	Inpatient Hospital Services	\$135.45	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.404 sets out the hospital facility fee guideline for inpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - 468 – REIMBURSEMENT IS BASED ON THE MEDICAL HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM METHODOLOGY.

Issues

Is the requestor entitled to additional payment?

Findings

This dispute regards inpatient services with payment subject to *DWC Hospital Facility Fee Guideline—Inpatient*, Rule 28 TAC §134.404, requiring maximum allowable reimbursement (MAR) to be the Medicare facility specific amount 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 28 TAC §134.404(f)(1)(A) requires payment for these services to be 143% of the Medicare facility specific amount, including any outlier payment.

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 28 TAC §134.404(d)(1) requires 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. The VBP credit for this admission was \$46.42, which will not be considered in calculating the Medicare facility amount.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 580. The service location is Rockwall, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$9,376.91. This amount multiplied by 143% results in a MAR of \$13,342.60.

The total allowable reimbursement for the services in dispute is \$13,342.60. The amount previously paid by the insurance carrier is \$13,408.98. No additional payment is recommended.

Conclusion

For the reasons above, the requestor failed to establish 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	January 10, 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 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.