



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

Houston Methodist Hospital

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-20-1509-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 18, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We did not request separate reimbursement for the implants so they should be paid in the DRG"

Amount in Dispute: \$1,068.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider is not entitled to any additional reimbursement beyond what the carrier has already paid."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 27 – 30, 2019	Inpatient hospital services	\$1,068.85	\$762.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

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 acute care hospital 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
 - 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional payment?

Findings

1. This dispute regards inpatient hospital facility services rendered from August 27 – 30, 2019 with payment subject to 28 TAC §134.404(f) that requires 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, as published annually in the Federal Register, with modifications set forth in the rules.

Separate reimbursement for implants was not requested. The Medicare facility amount will 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 freely available from www.cms.gov.

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.

2. Review of the submitted medical bill and supporting documentation finds the assigned DRG code is 460. The service location is Houston, TX. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$28,867.55. This amount multiplied by 143% results in a MAR of \$41,183.06.

The total recommended payment for the services in dispute is \$41,183.06.

The insurance carrier paid \$40,420.34.

The balance of \$762.72 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 \$762.72.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$762.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 20, 2020

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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.