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
MOTHER FRANCES HOSPITAL

Respondent Name
DEEP EAST TEXAS SELF INSURANCE

MFDR Tracking Number
M4-20-2474-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
June 03, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a 2 day inpatient stay that should pay at the IPPS fee schedule per TDI rule 134.404. The carrier originally paid $3261.00. We submitted an appeal due to an under payment and they have denied additional reimbursement. The carrier only paid on the Pharmacy charges when it should have paid per DRG."

Amount in Dispute: $4,978.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the Medical Dispute Resolution concerning claimant [injured employee] from Mother Frances Hospital for date of service 11/4/19-11/6/19. DRG Codes are bundled therefore, no additional payment is recommended."

Response Submitted by: Injury Management Organization Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 4, 2019 to November 6, 2019	Hospital Inpatient Service	$4,978.87	$4,968.28

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

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Reconsideration
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation. We find our original review to be correct. Therefore, no additional allowance appears to be warranted

Issues

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

Findings

1. This dispute regards inpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.404(f), 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, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at 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%.

   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.
2. Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 603. The service location is at Mother Frances Hospital in Tyler, Tx. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $5,754.74. This amount multiplied by 143% results in a MAR of $8,229.28.
3. The total allowable reimbursement for the services in dispute is $8,229.28. This amount less the amount previously paid by the insurance carrier of $3,261.00 leaves an amount due to the requestor of $4,968.28. 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 $4,968.28.

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 $4,968.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	[redacted] Medical Fee Dispute Resolution Officer	June 25, 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 the division 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 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 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.