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
The Medical Center of SE Texas

Respondent Name
XL Specialty Insurance Co

MFDR Tracking Number
M4-21-0078-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 14, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $190.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that nothing further is due."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19 – 21, 2019	Inpatient Hospital Services	$190.39	$0.00

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 guidelines for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 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
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

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

Findings

1. The requestor is seeking additional reimbursement for inpatient hospital services rendered November 19 – 21, 2019. The insurance carrier reduced the disputed service based on the workers' compensation jurisdictional fee schedule.

   28 Texas Administrative Code §134.404(f), requires the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective PaymentSystem (IPPS) formulas and factors available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   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.

   Rule §134.404(f)(1)(A) requires that since separate payment of the implants was not requested, the Medicare facility specific amount, including any outlier payment, be multiplied by 143%.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 512. The service location is Port Arthur, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $9,493.72. 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.

   This amount multiplied by 143% results in a MAR of $13,576.02.

2. The total recommended payment for the services in dispute is $13,576.02. The insurance carrier has paid $13,611.35. No additional payment is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

Authorized Signature

		October 15, 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 Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

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 instructions on the form. 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 listed on the form or to the field office handling the claim.

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