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
Methodist Hospital for Surgery

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-21-0142-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
September 29, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review enclosed letter from the provider regarding services performed which DRG code [redacted] is valid for services billed."

Amount in Dispute: $59,662.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The operative report does not support increased consumption of care due to BMI. …Z[redacted].41 is for BMI 40.0-44.9. Provider needs to document exact value."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 17 – 22, 2020	Inpatient hospital services	$59,662.95	$53,275.16

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:
   - 185 – Valid DRG and/or Medicare number required for review. Please re-submit bill with proper information for further processing
   - X598- Claim has been re-evaluated based on additional documentation submitted. No payment due.

Issues

1. Is the insurance carrier's position supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. The insurance carrier denied the disputed inpatient hospital stay as the DRG was not supported. Specifically, the respondent points to the BMI requirements of diagnosis code Z[redacted] was not documented. Review of the "Discharge Summary" Page 1, found the BMI upon admission was 40. The March 17, 2020 pre-operative visit indicates Risk Factors: anesthesia anticipated to last greater than 30 minutes, obesity and Pre anesthesia evaluation states "morbid obesity". The "Morse Fall Risk Assessment" lists the patient at high risk to due obesity and surgery in the past six weeks. The insurance carrier's position is not supported. The services in dispute will be reviewed per applicable fee guideline.

2. 28 TAC §134.404(f) 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. Medicare IPPS formulas and factors are 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.

   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.

   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%.

3. Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 454. The service location is Addison, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $37,255.36. This amount multiplied by 143% results in a MAR of $53,275.16. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $53,275.16.

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 $53,275.16, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		June 16, 2021
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.

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