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
Harlingen Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-21-1081-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 1, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB bill denied due to missing discharge summary. Please note the discharge summary is attached for review along with other medical records. In accordance with the TX WC fee schedule, services rendered should be paid at $13,790.22."

Amount in Dispute: $13,790.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Discharge Summary was not submitted per Rule 133.210(a) – Medical Documentation. Additionally, the facility can reference CMS Claims Processing Manual – Chapter 12 for documentation requirements related to the discharge summary."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 29-31, 2020	Inpatient hospital services	$13,790.22	$13,723.62

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:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the insurance carrier's position supported?
2. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking reimbursement for inpatient hospital services rendered in May 2020. The insurance carrier denied the service for missing information and the submitted information does not support the service being billed. In their position statement the respondent references a discharge summary as required by Rule 133.210 (a) and Chapter 12 of the CMS Claims Processing Manual.

   The Rule referenced above states medical documentation includes hospital records. The CMS Processing Manual states in pertinent part that the treating physician must meet evaluation and management guidelines and identifying the physician treating the patient.

   The physician documentation from the emergency department indicates the severity of the injury and reason for hospital admission. Review of the submitted report dictated by surgeon who performed surgery states, "patient is going to go home on Keflex and Tylenol No. 3. Follow up in our office."

   The insurance carrier's denial is not supported. The disputed service 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. 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%.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 909. The service location is Harlingen, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $9,596.94. This amount multiplied by 143% results in a MAR of $13,723.62.

   The total recommended payment for the services in dispute is $13,723.62. 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 $13,723.62.

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 $13,723.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		March 29, 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.

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.