TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
HOUSTON METHODIST HOSPITAL

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-21-2383-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
August 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 6, 2021 to April 16, 2021	Inpatient Hospital Service	$5,771.49	$5,693.49
	Total	$5,771.49	$5,693.49

Requestor's Position

"This is a 10-day inpatient stay that should pay per TDI rule 134.404. The Carrier originally paid $33796.20. We submitted an appeal due to an underpayment and implants were not requested to be processed separately. The Carrier denied our appeal only stating DRG paid at 143%.

Per the PC Pricer attached, I show the DRG rate to be $27669.71 x 143% =$39567.69. The carrier's payment of $33796.20 was underpaid. Therefore, we are seeking additional payment due to $5771.49."

Amount in Dispute: $5,771.49

Respondent's Position

"The office will maintain that reimbursement was made to the facility in accordance with the Division's rules and payment policies and no additional payment is owed."

Response Submitted by: State Office of Risk Management

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §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.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' Compensation jurisdictional fee schedule adjustment
- B13 – Previously paid payment for this claim/service may have been provided in a previous payment
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- W3 – Reporting purposed only

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 with payment subject to 28 TAC §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.

   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 implants was not requested. 28 TAC §134.404(f)(1)(A) requires that the Medicare facility specific amount be multiplied by 143%.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 029. The service location is Houston, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $27,669.71 (less VBP adjustment of $54.54) leaves an adjusted Medicare facility specific amount of $27,615.17. This amount multiplied by 143% results in a MAR of $39,489.69.

2. The total allowable reimbursement for the services in dispute is $39,489.69. The amount previously paid by the insurance carrier is $33,796.20. An additional amount is due to the requestor of $5,693.49.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement $5,693.49 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that State Office of Risk Management must remit to Houston Methodist Hospital $5,693.49 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted]	[redacted]	September 15, 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel*

a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD) and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.