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
MHHS HERMANN HOSPITAL

Respondent Name
EXECUTIVE RISK INDEMNITY

MFDR Tracking Number
M4-22-1051-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 2, 2022

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am filing this medical fee dispute on the above claim for [injured employee] due to carrier denied the bills for lack of itemized statements. I submitted an itemized statement with the original bill that is provided by Memorial Hermann. Due to the denial, I resubmitted the bill for date of service 05/20/21-06-04/21 with the itemized statement as a reconsideration. Upon contact with Corvel, I was informed that my reconsideration was also denied."

Amount in Dispute: $149,578.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A complete medical bill was received on 07/20/21 from MHHS Hermann Hospital, date(s) of service 05/20/21 through 06/04/21 in the amount of $149,578.00. A medical bill review was, conducted under bill id#3284913-1 and final action on 07/29/21 rendered in the form of denial based on lack of documentation since the provider failed to provide an itemized statement or implant invoices to substantiate its claim for reimbursement (CARC code 16: Service lacks info needed or has billing error(s)) was utilized in addition to a line comment. Please resubmit with hospital itemization for further payment consideration."

Response Submitted by: CORVEL

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2021 to June 04, 2021	Inpatient Hospital Services	$149,578.00	$39,111.59

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 – SVC lacks info needed or has billing error(s)
   - 252 – Attachment required to adjudicate claim/service
   - 226 – Info requested was not provided or was insuff
   - W3 – Appeal/Reconsideration

Issues

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

Findings

1. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states that:

   > The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > (A) 143 percent; unless
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

   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%.

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 492. The services were provided at MHHS Hermann Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $27,350.76. This amount multiplied by 143% results in a MAR of $39,111.59.

3. The total allowable reimbursement for the services in dispute is $39,111.59. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $39,111.59. 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 $39,111.59.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $39,111.59 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

[redacted]	[redacted]	February 25, 2022
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 28 Texas Administrative Code §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 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 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 with the Division. **Please include a copy of the *Medical Fee Dispute Resolution 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.