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
MHHS THE WOODLANDS HOSPITAL

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-22-1248-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 23, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 06, 2021 to April 12, 2021	Hospital Inpatient Service	$66,922.50	$15,057.11
	Total	$66,922.50	$15,057.11

Requestor's Position

"This is a bill for services provided by Memorial Hermann Hospital for a workers comp injury for the above named patient. The bill was denied by the carrier for timely filing. However, per Texas Administrative Code Rule §133.20, we billed the carrier within 95 days of being notified as this was work related."

Amount in Dispute: $66,922.50

Respondent's Position

The Austin carrier representative for Zurich American Insurance is Flahive, Ogden & Latson. Flahive, Ogden & Latson was notified of this medical fee dispute on March 01, 2022. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base

this decision on the information available as authorized under §133.307(d)(1).

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 Texas Administrative Code TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.404 sets out the acute care hospital fee guideline for inpatient services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 5721 – To avoid duplicate bill denial for all reconsideration/adjustments/additional payment requests submit a copy of this EOR or clear notat
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- 29 – The time limit for filing has expired
- 4271 – Per TX Labor Code Sec 408.027 providers submit bills to payors within 95 days of the date of service
- P12 – Workers Compensation Jurisdictional Fee Schedule adjustment
- 170 – Reimbursement is based on the outpatient fee schedule

Issues

1. Is the insurance carrier denial of timely filing 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 service with denial reason listed below:
    - 90096 – The time limit for filing has expired
    - 29 – The time limit for filing has expired
    - 4271 – Per TX Labor Code Sec 408.027 providers submit bills to payors within 95 days of the date of service

28 TAC §133.20(b) states "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care

provider shall not submit a medical bill later than the 95th day after the date the services are provided."

Texas Labor Code 408.0272 (b) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or

(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;."

Review of the submitted documentation finds the provider billed the injured workers health insurance on July 14, 2021.

Notification to the workers comp insurance on September 27, 2021. Therefore, the provider meets the requirements as described above. Insurance carrier denial is not supported.

2. 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 200. The service location is The Woodlands. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $10,529.45. This amount multiplied by 143% results in a MAR of $15,057.11.

3. 28 TAC §134.404 (e) states Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

   The total allowable reimbursement for the services in dispute is $15,057.11. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $15,057.11. This amount is recommended.

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 of $15,057.11 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 ZURICH AMERICAN INSURANCE CO must remit to MHHS THE WOODLANDS HOSPITAL $15,057.11 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted]	[redacted]	June 8 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 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.