TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
TARRANT COUNTY HOSPITAL DISTRICT

Respondent Name
AIU INSURANCE CO

MFDR Tracking Number
M4-22-1356-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 27, 2021 to September 29, 2021	Hospital Inpatient	$33,554.09	$13,904.22
	Total	$33,554.09	$13,904.22

Requestor's Position

"This is a bill for an inpatient stay from September 27, 2021 – September 29, 2021 and included medical/surgical supplies. Per the www.cms.gov/medicare-fee-for-service-Payment/PCPricer/index.html calculator this should pay 33345.52 x 143% = $47684.09 for the DRG code 552. We submitted an appeal for underpayment with the Medicare allowable that shows what the markup should be."

Amount in Dispute: $33,554.09

Respondent's Position

"The provider filed a DWC-60 seeking medical fee dispute resolution for dates of service between September 27, 2021 and September 29, 2021. The provider acknowledged that the carrier had already reimbursed the amount of $14,130. That is the amount the provider billed on

its UB-04. The provider is seeking reimbursement of $33,554.09 … Following the carrier's receipt of the DWC-60, the carrier has reprocessed the provider's bill. Based upon the revaluation, the carrier is paying an additional amount of $19,424.09 plus interest."

Response Submitted by: Flahive, Ogden & Latson

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:

- 5624 – Internal Use only
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation we find our original review to be correct. Therefore, no additional allowance appears to be warranted
- 2005 – NO additional reimbursement. Allowed after review of appeal/reconsideration
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – Bill is a reconsideration or appeal
- QA – The amount is due is bundling or including of services
- P00C – Internal use 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 552. The service location is Fort Worth, TX. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $33,187.63. This amount multiplied by 143% results in a MAR of $47,458.31.

2. The total allowable reimbursement for the services in dispute is $47,458.31. This amount less the amount previously paid by the insurance carrier of $33,554.09 leaves an amount due to the requestor of $13,904.22. 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 $13,904.22 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 AIU Insurance Co must remit to Tarrant County Hospital District $13,904.22 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted] [redacted] June 9, 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.