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
Providence Memorial Hospital

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-22-1508-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
March 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 10 - 12, 2021	300	$629.00	$0.00
May 10 - 12, 2021	250	$3121.00	$0.00
May 10 - 12, 2021	636	$1928.00	$0.00
May 10 - 12, 2021	278	$32410.00	$0.00
May 10 - 12, 2021	320	$1380.00	$0.00
May 10 - 12, 2021	370	$9930.00	$0.00
May 10 - 12, 2021	300	$495.00	$0.00
May 10 - 12, 2021	111	$4194.00	$0.00
May 10 - 12, 2021	360	$66446.00	$13,646.00
May 10 - 12, 2021	710	$15931.00	$0.00
	Total	$13646.00	$13,646.00

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Gallagher Bassett, but the bill was not paid with forty-five days. We requested Gallagher Bassett reconsider the denial. However, despite the Hospital's efforts and Request for Reconsideration Gallagher Bassett has not rendered payment."

Amount in Dispute: $13,646.00

Respondent's Position

The Austin carrier representative for LM Insurance Corp is JT Parker & Associates. The representative was notified of this medical fee dispute on March 29, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 the payment for the disputed services with the following claim adjustment codes:

- 18 – Duplicate claim/service

Issues

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

Findings

1. The requestor is seeking reimbursement for inpatient hospital services rendered in May 2021. The insurance carrier denied as a duplicate claim however, insufficient evidence was found to support the claim had been previously adjudicated or paid. The services in dispute will be reviewed per applicable fee guideline.
2. These inpatient hospital facility services are 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. 28 TAC §134.404(f)(1)(A) requires that the Medicare facility specific amount be multiplied by 143%.

DWC Rule §134.404 (e) (2) states in pertinent part, regardless of billed amount, reimbursement amount when no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables. Review of the medical fill found separate reimbursement for implants was not requested.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 473. The service location is El Paso, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $15,691.09. This amount multiplied by 143% results in a MAR of $22,438.26.

The total recommended payment for the services in dispute is $22,438.26. The requestor is seeking $13,646.00. 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 $13,646.00 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 Respondent must remit to the requestor $13,646.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 20, 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.