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
BAPTIST MEDICAL CENTER

Respondent Name
ARCH INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-22-1773-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 12, 2021 to May 13, 2021	Inpatient Hospital Service	$24,368.19	$103.11

Requestor's Position

"The Hospital's records reflect the patient was injured in a work-related injury. The Hospital is entitled to reimbursement because it provided the medically necessary procedure for treatment directly related to the patient's work-related injury."

Amount in Dispute: $24,368.19

Respondent's Position

"The following components of the review has now been completed:

Fee schedule

Our Fee schedule team has determined that the provider is not due any additional allowance."

Response Submitted by: Gallagher Bassett

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

- 5280 – Bill qualifies for foresight review
- 5721 – To avoid duplicate bill denial for all reconsideration/adjustments/additional payment requests submit a copy of this EOR or clear notation
- 90223 – Workers' compensation jurisdictional fee schedule adjustment
- 5280 – Bill qualifies fo foresight review
- P12 – Workers compensation jurisdictional fee schedule adjustment
- 4896 – Payment made per medicares IPPS methododology with the applicable state markup
- 5403 – CV: this bill qualified for the clinical vadlidation program, no reductions applied

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 982. The services were provided at BAPTIST MEDICAL CENTER. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $17,149.62. This amount multiplied by 143% results in a MAR of $24,523.96.

3. The total allowable reimbursement for the services in dispute is $24,523.96. The amount previously paid by the insurance carrier is $24,420.85. Reimbursement of $103.11 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 $103.11 is due.

Order

It is ordered that ARCH INDEMNITY INSURANCE must remit to BAPTIST MEDICAL CENTER CO $103.11 plus applicable accrued interest within 30 days of receiving this order in accordance

with 28 TAC §134.130.

Authorized Signature

[redacted]	[redacted]	May 13, 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.