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
TARRANT COUNTY HOSPITAL DISTRICT

Respondent Name
SOMPO AMERICA INSURANCE CO

MFDR Tracking Number
M4-22-1788-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 25, 2021 to November 30, 2021	Inpatient Hospital Service	$31,177.62	$31,176.62
	Total	$31,177.62	$31,176.62

Requestor's Position

"This is a bill for an inpatient hospital stay on November 25, 2021 – November 30, 2021, and included medical/surgical supplies. Per the https://webpricer.cms.gov/#/pricer/ipps this should have paid 25694.54 x 143% = 36743.19. The carrier originally paid $5565.57. We submitted an appeal for underpayment with the Medicare allowable that shows what the markup should be. The carrier did not pay any additional amount stating the claim was processed properly. There is a balance left of $31177.62, this is the amount we are seeking for medical dispute."

Amount in Dispute: $31,177.62

Respondent's Position

"The Provider filed a DWC-60 requesting Medical Fee Dispute Resolution for dates of service between November 25, 2021 and November 30, 2021. The Provider billed a total of $21,710.00.

The Provider acknowledged that the Carrier had reimbursed it the amount of $5,565.57. The Provider is seeking an additional reimbursement of $31,177.62."

Response Submitted by: Flahive, Ogden & Latson

Supplemental Position Statement

"Carrier has previously responded to this dispute on May 10, 2022. In the Carrier's initial response, it failed to include the Provider's request for reconsideration and the Carrier's EOB in response to it dated March 22, 2022. We are not attaching a copy of these documents."

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:

- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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.

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 639. The service location is Fort Worth, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $25,694.54. This amount multiplied by 143% results in a MAR of $36,743.19.

2. 28 TAC §134.404(e) states "(e) Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

   (2) if 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.

   (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 $36,743.19.

   This amount less the amount previously paid by the insurance carrier of $5,566.57 leaves an amount due to the requestor of $31,176.62.

   Based upon the documentation submitted and the *Table of Disputed Services* the requestor is seeking reimbursement of $31,177.62.

   Therefore, reimbursement of $31,176.62 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 $31,176.62 is due.

Order

It is ordered that SOMPO America Insurance Co must remit to Tarrant County Hospital District $31,176.62 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
[redacted]	[redacted]	June 9, 2022
Signature	Director of Medical Fee Dispute Resolution	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.