



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Covenant Med Center

Respondent Name

Safety National Casualty Corp

MFDR Tracking Number

M4-22-2156-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 3-4, 2021	Inpatient Hospital	\$9,769.87	\$9,628.89
Total		\$9,769.87	\$9,628.89

Requestor's Position

"This bill is a one-day inpatient stay that should pay per TDI rule 134.404. ...Per the DRG rate listed below, the payment amount is \$21388.82 x 143% = \$30586.01. The carrier paid a total of \$20816.14 leaving a balance due of \$9769.87 and this is the amount of our dispute."

Amount in Dispute: \$9,769.87

Respondent's Position

"It is the carrier's position that the provider is not entitled to any additional reimbursement. ...The provider has been paid all of the monies that the provider is entitled to."

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 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:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- CO – Contractual obligation (Patient may not be billed for these)

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 additional reimbursement for an inpatient hospital stay rendered June third through fourth, 2021. The insurance carrier reduced the amount paid based on charges exceeding fee arrangement and workers' compensation fee schedule.

DWC Rule 28 TAC §134.404 (e) (1) (2) states in pertinent part, regardless of billed amount, reimbursement shall be 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 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 of implants.

Review of the submitted documentation found insufficient evidence to support a fee schedule set in a contract. The insurance carrier's reduction based on fee arrangement is not supported. The applicable workers' compensation fee guideline is calculated as follows.

The services in dispute 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.

Separate reimbursement for implants was not requested. DWC Rule 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 492. The service location is Lubbock, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$21,290.23. This amount multiplied by 143% results in a MAR of \$30,445.03.

2. The total recommended payment for the services in dispute is \$30,445.03. The insurance carrier has paid \$20,816.14. The remaining balance of \$9,628.89 is due to the requestor.

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 \$9,628.89 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 Safety National Casualty Corp must remit to Covenant Med Center \$9,628.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	June 29, 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 electrónico CompConnection@tdi.texas.gov.