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**
CRESCENT MEDICAL CENTER

**Respondent Name**
LIBERTY INSURANCE CORP

**MFDR Tracking Number**
M4-22-2609-01

**Carrier's Austin Representative**
Box Number 01

**DWC Date Received**
August 12, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| August 12, 2021 to August 17, 2021 | Inpatient Hospital Service | $28,779.00 | $0.00 |
| | **Total** | $28,779.00 | $0.00 |

## Requestor's Position

I do not agree with the determination of my claim. **MY REASONS ARE:**

The bill is still underpaid. According to the eob, the bill was processed per Medicare's IPPS with applicable state markup. The allowed per Medicare's IPPS is $45,464.62. Texas state markup is 143%. The total expected allowed was $65,0141.41. Pleas pay the additional $28,779.00.

**Amount in Dispute:** $28,779.00

## Respondent's Position

The IPPS calculation provided by Crescent Medical Center, shows the Medicare allowance with the implants factored into the charged amount. This would be correct if they were not being paid separately. The implants are being paid separately per hospital request, so those are not

included in the total put into the IPPS calculator.

**Response Submitted by:** Liberty Mutual Insurance

## 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) §134.404 sets out the acute care hospital fee guideline for inpatient services.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 11 – The recommended allowance for the supply was based on the attached invoice
- 4157 – Outlier payment applied to covered Inpatient Hospital services
- 4896 – Payment made per Medicare IPPS Methodology, with the applicable state markup
- 5732 – Insurance carrier payment to the health care provider shall be according to commission medical policies and fee guidelines in effect on the date(s) of service(s), health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not be compensable or the insurance carrier is relieved of the liability under labor code 408.024
- 5792 – To obtain information about the status of your medical bill submissions and to learn about the reconsideration process, or the benefits of paperless billing & electronic payment (EFT), visit our provider support website at WWW.LIBERTYMUUTALPROVIDERSUPPORT.COM
- B13 – Previously paid, payment for this claim/service may have been provide in a previous payment previously paid.
- W3 – Medical bills for this claim should be submitted to the 'send bills to' address referenced in the upper left corner of the EOP
- ZC72 – In the event this payment needs to be returned to the payer, return the check to PO BOX 734732 Chicago IL 60673-4372. To submit a dispute or appeal, please see the address in the upper left-hand corner of this EOB
- 8 – The supply charge was disallowed as it was not adequately identified. Please

resubmit with invoice

- Z850 – Medical bills for this claim should be submitted to 'send bills to' address referenced in the upper left corner of the EOP

Issues

1. What is the applicable rule for determining reimbursement for the dispute service?

2. What is the recommended payment amount for the service in dispute?

3. Is the requestor entitled to additional reimbursement?

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.

   Review of the submitted documentation and DWC060 form finds that while separate reimbursement for implantables was requested and reimbursement is calculated according to §134.404(f)(1)(B); the services in dispute are only for the facility charges and not the implantables. For that reason, this decision will only address the facility specific reimbursement amount.

2. Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment shall be multiplied by 108%. Additionally, §134.404(f)(2) states that "When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g)". The total billed amount of the implantables will not be included in the calculation of the Medicare specific facility amount as they were separately reimbursed under subsection (g).

   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 470. The services were provided at Lancaster TX. Additionally, TAC Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $22,347.60. This amount multiplied by 108% results in a MAR of $24,135.41.

| Billed charges | Implant charges | Amount entered Pricer | MCR DRG payment | MCR DRG x 108% |
|---|---|---|---|---|
| $157,427.10 | $56,465.00 | $100,962.10 | $22,347.60 | $24,135.41 |

3. The total allowable reimbursement for the disputed services is $24,135.41. The amount previously paid by the insurance carrier is $36,235.41. No additional reimbursement can be 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 not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

**Authorized Signature**

[redacted]

Signature

[redacted]

Medical Fee Dispute Resolution Officer

September 15, 2022

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.