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
MHHS The Woodlands Hospital

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-23-2620-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 13, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 10 – 13, 2022	Inpatient Stay	$41,051.25	$11,601.90
	Total	$41,051.25	$11,601.90

Requestor's Position

"This bill for services provided by Memorial Hermann Hospital for a workers comp injury for the above name patient. As of right now, the carrier has not processed the bill for payment. They have denied this bill multiple times stating lack of medical records but we have submitted the bill along with the IB and Medical records to them multiple times."

Amount in Dispute: $41,051.25

Respondent's Position

The Austin carrier representative for Zurich American Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on June 20, 2023.

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.

Response Submitted by: N/A

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 TAC §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:

- 5407 – CV: Reconsideration no additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation.
- 5721 – To avoid duplicate bill denial for all reconsideration/adjustments/additional payment requests, submit a copy of the EOR or clear notation.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did the respondent support their denial?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking reimbursement of inpatient hospital services rendered in October 2022. The insurance carrier denied the claim and reconsideration as claim lacking information. Review of the submitted documents found required elements were submitted. The insurance carrier did not submit a position statement. This dispute will be reviewed per applicable fee guideline.
2. This dispute regards inpatient hospital facility services with payment subject to DWC Rule 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. 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 921. The service location is The Woodlands, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $8,113.22. This amount multiplied by 143% results in a MAR of $11,601.90.

3. The total recommended payment for the services in dispute is $11,601.90. 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 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the MHHS The Woodlands Hospital is entitled to additional reimbursement for the disputed services. It is ordered that Zurich American Insurance Co must remit to MHHS The Woodlands Hospital $11,601.90 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 29, 2023 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.