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
ZURICH AMERICAN INS CO OF ILLINOIS

MFDR Tracking Number
M4-24-0326-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 10, 2022 to December 11, 2022	Inpatient Hospital	$20,681.71	$20,681.71
	Total	$20,681.71	$20,681.71

Requestor's Position

"This bill is a bill for an inpatient stay on December 10, 2022-December 11, 2022. Per https://webpricer.cms.gov/#/pricer/ipps this should pay $38,287.21 x 143% = $54,750.71. The carrier originally paid $34,069.00. We submitted an appeal for underpayment with the Medicare allowable. The carrier did not pay any additional amount stating no allowance change."

Amount in Dispute: $20,681.71

Respondent's Position

"The provider filed a DWC-60 seeking medical fee dispute resolution for dates of service of December 10th and December 11, 2022. The provider billed $34,069.00. The provider acknowledged that it was paid that amount. The provider is seeking additional payment of $20,681.71 … The initial EOB recommended payment of $34,069.00. The second EOB recommended the same allowance."

Response Submitted by: Flahive Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §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:

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

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 pertains to inpatient hospital facility services with payment subject to 28 TAC 134.404(f), which requires 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 "Value-Based Purchasing (VBP) adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's VBP program is an initiative to improve quality of care in the Medicare system. However, such programs conflict with TLC 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%.

28 TAC §134.404 (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).

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 042. The service location is Fort Worth, TX. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is $38,287.21. This amount multiplied by 143% results in a MAR of $54,750.71.

2. The total allowable reimbursement for the services in dispute is $54,750.71. The amount previously paid by the insurance carrier is $34,069.00. The requestor is seeking additional reimbursement in the amount of $20,681.71. 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 of $20,681.71 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 ZURICH AMERICAN INS CO OF ILLINOIS must remit to TARRANT COUNTY HOSPITAL DISTRICT $20,681.71 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	January 9, 2024 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.