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
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
OBI NATIONAL INSURANCE CO

MFDR Tracking Number
M4-24-0552-01

Carrier's Austin Representative
Box Number 29

DWC Date Received
November 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 19, 2023 to January 28, 2023	Inpatient Hospital Services	$7,988.78	$7,988.78
	Total	$7,988.78	$7,988.78

Requestor's Position

"After reviewing the account, we have concluded that reimbursement received was inaccurate. WCERA_WORKERS' COMPENSATION EXPECTED REIMBURSEMENT AMOUNT – DRG 163 - $38,955.24 (143%) = ERA $55,706.00. The reimbursement amount should be $55,706.00. Payment received was only $47,700.62 thus, according to these calculations; there is a pending payment in the amount of $8,005.37."

Amount in Dispute: $7,988.78

Respondent's Position

The respondent did not submit a response to the DWC060 request.

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 §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:

- 253, 252 – In order to review this charge please submit a copy of the certified invoice
- 468, P12 – Pricing is based on the medical hospital inpatient prospective payment system methodology
- C10, 192 – non standard adjustment code from paper remittance
- 350 – Bill has been identified as a request for reconsideration or appeal
- 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
- B12 – No description available

Issues

1. Did the respondent respond to the DWC 60 request the requestor submitted?
2. Is the respondent's denial reason(s) supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to additional payment?

Findings

1. The Austin carrier representative for OBI National Insurance Co is Dean G Pappas Law Firm. Dean G Pappas Law Firm was notified of this medical fee dispute on November 7, 2023. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).
2. The insurance carrier denied the dispute services with denial reduction code 253 – "in order to review this charge please submit a copy of the certified invoice."

   28 TAC §134.404 (g) states Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and

discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.

Review of the submitted documentation provided by the health care provider does not support implants is in dispute. Therefore, insurance carrier denial is not supported.

3. The dispute pertains to 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.

   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 163. The service location is Edinburg, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $44,156.70. This amount multiplied by 143% results in a MAR of $63,144.08.

4. The maximum allowable reimbursement is $63,144.08. The amount previously paid by the insurance carrier is $47,717.22, as a result the requestor is entitled to $15,426.86. The requestor is seeking an additional reimbursement in the amount of $7,988.78. 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 $7,988.78 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 OBI NATIONAL INSURANCE CO must remit to DOCTORS HOSPITAL AT RENAISSANCE $7,988.78 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted] January 5, 2024

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 electronico CompConnection@tdi.texas.gov.