TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
North Central Baptist Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-24-0643-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 9, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3 – 6, 2023	872	$1,522.17	$105.43
	Total	$1,522.17	$105.43

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a reconsideration submitted to the insurance carrier dated August 11, 2023 that states, "After reviewing the payment, we realized that there is an underpayment on the claim. According to our contract with Texas Mutual, all inpatient should be paid at 143% of Medicare Fee Schedule. Using this calculation, the reimbursement for inpatient should have been $11,815.33. We have received a payment of $10, 293.16, leaving an underpayment of $1,522.17."

Supplemental response submitted January 9, 2024

Please continue with the dispute, we did receive a payment in the amount $10293.16, however claim is still underpaid per the Texas state fee schedule."

Amount in Dispute: $1,522.17

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 – Guidelines for Medical Services, Charges and Payments."

Response Submitted by: Texas Mutual

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) §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 reduced the payment for the disputed services with the following claim adjustment codes:

- A15 – The reimbursement for health care services are subject to Workwell, TX Contracts, a certified WC HCN (INS Code Ch. 1305).
- CAC-P12 Workers' compensation jurisdictional fee schedule adjustment.
- CAC-131 – Claim specific negotiated discount.
- 468 – Pricing is based on the medical hospital inpatient prospective payment system methodology.
- 729 – This bill was reviewed in accordance with your Coventry contract.

Issues

1. Are the disputed services subject to Certified Healthcare Network?
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 indicates in the submitted reconsideration that they have a contract with Texas Mutual. The insurance carrier indicates on their explanation of benefits that the services are subject to Workwell, Tx certified health care contract.

   Neither party submitted sufficient evidence to support whether the injured worker is enrolled in a certified healthcare network or that a contract exists between the two parties. These reductions

will not be considered in this review. The reduction based on workers' compensation fee schedule will be reviewed as found below.

2. This dispute regards inpatient hospital facility services rendered in May of 2023 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 872. The service location is San Antonio, Texas.

   Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $7,271.74. This amount multiplied by 143% results in a MAR of $10,398.59.

2. The total recommended payment for the services in dispute is $10,398.59. The insurance carrier paid $10,293.16. The requestor is entitled to an additional payment of $105.43. 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 $105.43 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 Texas Mutual Insurance Co must remit to North Central Baptist Hospital $105.43 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 15, 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.