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

General Information

Requestor Name
VHS Brownsville Hospital

Respondent Name
WCF National Insurance Co

MFDR Tracking Number
M4-24-1301-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 14, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 17, 2023	R&B/Semi/2Bedigen Class	Left blank	$0.00
March 17, 2023	250 PHARMACY	Left blank	$0.00
March 17, 2023	258 IV SOLUTIONS	Left blank	$0.00
March 17, 2023	278 SUPPLY/IMPLANTS	Left blank	$0.00
March 17, 2023	300 LABORATORY OR LAB	Left blank	$0.00
March 17, 2023	310 PATHOLOGY LAB	Left blank	$0.00
March 17, 2023	320 DX X-RAY	Left blank	$0.00
March 17, 2023	360 OR SERVICES	Left blank	$0.00
March 17, 2023	370 ANETSTHESIA	Left blank	$0.00
March 24, 2023	424 PHYS THERP/EVAL	Left blank	$0.00
March 24, 2023	430 OCCUPATIONAL THER	Left blank	$0.00
March 24, 2023	710 RECOVERY ROOM	Left blank	$0.00
March 14, 2023	730 EKG/ECG	Left blank	$0.00
	Total	$3,472.28	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated August 1, 2023 that states, "After reviewing the payment, we realized that there is an underpayment on the claim. According to our contract with Gallagher Bassett, we are entitled to receive $29,343.35. We have received a payment of

$25,870.59 and we are requesting an additional payment in the amount of $3,472.76."

Amount in Dispute: $3,472.28

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Supplemental response March 13, 2024

"Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett

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:

- 5721 – To avoid duplicate bill denial, for all reconsiderations/adjustments/additional payment requests, submit a copy of this EOR or clear notation that a recon is.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4895 – Payment made per Medicare's IPPS methodology, with the applicable state markup.

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 regards inpatient hospital facility services rendered in March 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 483. The service location is Brownsville, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $18,091.31. This amount multiplied by 143% results in a MAR of $25,870.57.

2. The total recommended payment for the services in dispute is $25,870.57. The insurance carrier paid $25,871.07. No additional payment 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		March 20, 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.