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
MHHS Hermann Hospital

Respondent Name
Great American Alliance Insurance Co

MFDR Tracking Number
M4-24-1796-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 8, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 12-17, 2023	Inpatient Stay	$103,094.51	$18,530.73
	Total	$103,094.51	$18,530.73

Requestor's Position

"This is a bill for services provided by Memorial Hermann Hospital for a workers comp injury for the above named patient. As of right now, the inpatient medical bill is underpaid and not paid per Texas fee schedule."

Amount in Dispute: $103,094.51

Respondent's Position

"Respondent contends the medical bill was reviewed on two separate occasions with the same conclusion after proper application of Workers' Compensation Jurisdictional Fee Schedule Adjustment and pricing per Medicare Transfer Policy, leaving a recommended allowance of $36,132.99 which was timely paid by the Respondent. Respondent timely and properly applied the appropriate Texas Workers' Compensation Jurisdictional Fee Schedule Adjustment and price according to the Medicare Transfer Policy under the Inpatient Prospective Payment System."

Response Submitted by: Silvera Deary Ray

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:

- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 375 – Please see special *Note* below.
- 687 – This service was priced according to the Medicare Transfer policy under Inpatient Prospective Payment System.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W1 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Is the respondent's reduction in payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. This dispute regards inpatient hospital facility services rendered in July 2023. The insurance carrier reduced the payment based on Medicare Transfer Policy.

   Review of the submitted medical bill found in box 17 the following "01". The Medicare Claims Processing Manual Chapter 25 indicates, "FL 17 – Patient Discharge Status. Required. (For all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services.) This code indicates the patient's discharge status as of the "Through" date of the billing period. Codes used for Medicare claim are available from Medicare contractors. Codes are also

available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

The definition of "01" Patient status at https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r1718cp.pdf –, "Discharged to home or self-care (routine discharge).

Review of the submitted "Discharge Summary" on page 3 indicates, "Discharge disposition: Home."

Based on this review, the insurance carrier's reduction is not supported. The disputed services will be reviewed per applicable fee guideline.

2. The payment of inpatient hospital services is subject to DWC Rule 28 TAC §134.404(f), that 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.

   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 0440. The service location is Houston, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $38,226.38. This amount multiplied by 143% results in a MAR of $54, 663.72.

2. The total recommended payment for the services in dispute is $54,663.72. The insurance carrier paid $36,132.99. The requestor is entitled to an additional payment of $18,530.73. 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 $18,530.73 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 Great American Alliance Insurance Co must remit to MHHS $18,530.73 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 30, 2024
Signature	Medical Fee Dispute Resolution Officer	Date
		May 30, 2024
Signature	Director Medical Fee Dispute Resolution	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.