

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

UNIVERSITY MEDICAL CENTER

**Respondent Name**

BERKLEY REGIONAL INS CO

**MFDR Tracking Number**

M4-24-1897-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

April 23, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 8, 2023, to December 09, 2023	Inpatient Hospital	\$1,485.03	\$1,464.15
<b>Total</b>		\$1,485.03	\$1,464.15

### Requestor's Position

"This bill is for a 1-day inpatient stay that should be paid per TDI rule 134.404. The DRG was 578. This bill should have paid \$14007.73 x143% =\$27514.83. The carrier originally paid \$26029.80. An appeal was submitted, and the carrier denied additional reimbursement. We are seeking additional reimbursement of \$1485.03."

**Amount in Dispute:** \$1,485.03

### Respondent's Position

"The provider filed a request for medical fee dispute resolution for dates of service of December 8 and December 9, 2023. The provider billed \$44,524.20. The provider acknowledges that the carrier reimbursed it the amount of \$26,029.80. The provider is seeking additional payment of \$1,485.03... It remains the carrier's position that it has fully reimbursed the provider. It has paid the provider based upon the medical fee guidelines. No additional monies are owed to the provider."

**Response Submitted by:** Flahive Ogden & Latson

## 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:

- 993 - Reduction is based on the Inpatient Fee Schedule.
- ANS1193 - 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- ANSIP12 - P12 - Workers' compensation jurisdictional fee schedule adjustment.
- CIQ378 - This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
- RE555 - Previous recommended history on DCN(s): 1000118077=\$2,830.74 (993, ANSIP12, BMMSBRC}
- W3 - W3 - TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.
- RE555 - Previous recommended history on DCN(s): 1000118077=\$2,231.79 (993, ANSIP12}
- 773 - Reimbursement is in accordance with the TDI Workers' Compensation State Fee Schedule Adjustment and Guidelines.
- RE555 - Previous recommended history on DCN(s): 1000118077=\$65.07 (993, ANSIP12)
- RE555 - Previous recommended history on DCN(s): 1000118077=\$1,098.74 (993, ANSIP12)
- RE555 - Previous recommended history on DCN(s): 1000118077=\$6.42 (993, ANSIP12)
- RE555 Previous recommended history on DCN(s): 1000118077=\$250.22 (993, ANSIP12)
- RE555 - Previous recommended history on DCN(s): 1000118077=\$138.56 (993, ANSIP12)
- RE555 - Previous recommended history on DCN(s): 1000118077=\$309.26 (993, ANSIP12)
- RE555 - Previous recommended history on DCN(s): 1000118077=\$9,821.64 (993, ANSIP12)
- RE555 - Previous recommended history on DCN(s): 1000118077=\$4,501.59 (993, ANSIP12)
- RE555 - Previous recommended history on DCN(s): 1000118077=\$4,634.29 (993, ANSIP12)

- RE555 Previous recommended history on DCN(s): 1000118077=\$141.48 (993, ANSIP12)

### 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), 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](http://www.cms.gov).

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.

A review of the submitted documentation finds that 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%.

A review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 578. The service location is Lubbock, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$19,226.54. This amount multiplied by 143% results in a MAR of \$27,493.95.

2. The total allowable reimbursement for the services in dispute is \$27,493.95. The amount previously paid by the insurance carrier is \$26,029.80.

The requestor is seeking reimbursement of \$1,485.03. The recommended amount of \$1,464.15 is allowed.

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 \$1,464.15 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 BERKLEY REGIONAL INS CO must remit to UNIVERSITY MEDICAL CENTER \$1,464.15 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**



May 24, 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](http://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, call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto: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](mailto:CompConnection@tdi.texas.gov).