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
TRI-STATE INSURANCE COMPANY OF MINNESOTA

MFDR Tracking Number
M4-24-1949-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 6, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 31, 2023, to August 2, 2023	Inpatient Hospital	$59,912.93	$7,344.43
	Total	$59,912.93	$7,344.43

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: $59,912.93

Respondent's Position

"The carrier's EOR dated October 19, 2023 identified each line item, the billed amount, the recommended allowance and the reason for the reduction from the billed amount to the recommended allowance. ... The provider has been paid $17,080.07. The provider has not provided proof to support any additional reimbursement. No additional monies are due."

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 §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:

- BT100 – Unless otherwise specified, services has been reviewed to the State Fee schedule
- BT975 – No additional allowance is recommended
- TX193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- TXP12 – Workers Compensation Jurisdictional fee schedule adjustment

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 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.

   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 520. The service location is Houston, TX. Based on DRG code, service location, and

bill-specific information, the Medicare facility specific amount is $17,080.07. This amount multiplied by 143% results in a MAR of $24,424.50.

2. The total allowable reimbursement for the services in dispute is $24,424.50. The amount previously paid by the insurance carrier is $17,080.07. The requestor is seeking additional reimbursement in the amount of $59,912.93. The recommended amount allowed for reimbursement is $7,344.43.

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 $7,344.43 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 TRIS STATE INSURANCE COMPANY OF MINNESOTA must remit to MHHS HERMANN HOSPITAL $7,344.43 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

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.