



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

MHHS Hermann Hospital

Respondent Name

Indemnity Insurance Co. of North America

MFDR Tracking Number

M4-25-0831-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

December 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 5, 2024, to July 12, 2024	Inpatient Stay	\$147,883.81	\$15,287.93

Requestor's Position

"As of right now, the inpatient medical bill is underpaid and not paid per Texas fee schedule."

Amount in Dispute: \$147,883.81

Respondent's Position

"Please see the attached EOBs. Respondent paid the medical bill pursuant to the Medicare IPPS methodology with the applicable state markup. In conclusion, no additional reimbursement is owed based on the proper fee schedule."

Response submitted by: Downs & Stanford, P.C.

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.

Adjustment or Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 4896 – PAYMENT MADE PER MEDICARE'S IPPS METHODOLOGY, WITH THE APPLICABLE STATE MARKUP.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3– THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
- 2005 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- 5158 - EBILL RECON MANUALLY PROCESSED.

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 involves emergency room and inpatient hospital facility services rendered July 5, 2024, to July 12, 2024.

DWC finds that 28 TAC §134.404(f) applies to the maximum allowable reimbursement (MAR) of the services in dispute, which states in pertinent part, "(f) The reimbursement calculation used

for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 143 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at <http://www.cms.gov>.

2. The requestor is seeking additional reimbursement in the amount of \$147,883.81 for emergency room and inpatient hospital facility services rendered July 5, 2024, to July 12, 2024.

DWC 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%.

A review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 493. The service location is Houston, TX, Locality 18. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$27,190.82. This amount multiplied by 143% results in a MAR of \$38,882.87.

The total recommended payment for the services in dispute is \$38,882.87. The insurance carrier paid \$23,594.94. The difference between the MAR and the insurance carrier's previous reimbursement amount is \$15,287.93. This amount of additional reimbursement is recommended.

DWC finds that the requestor is entitled to additional reimbursement in the amount of \$15,287.93 for the services in dispute.

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 requestor has established that additional reimbursement in the amount of \$15,287.93 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 Indemnity Insurance Co.

of North America must remit to MHHS Hermann Hospital \$15,287.93 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	February 25, 2025
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 electrónico CompConnection@tdi.texas.gov.