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
University Medical Center

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-25-1856-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
April 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 20, 2024, to December 21, 2024	EC visit/Inpatient	$19,877.89	$19,877.89

Requestor's Position

"...patient was brought in on 12/20/2024 and discharged on 12/21/2024. Texas Mutual has denied our claim stating: 892-BILL DOES NOT MEET 2 MIDNIGHT RULE REQUIREMENTS

"Then they promptly sent a settlement offer asking if we would accept $15K since our bill was denied. We rejected their offer as we do not agree with their denial because per CMS rules stating: the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supported that reasonable expectation...

"UMC's position is that Texas Mutual owes $19,877.89..."

Amount in Dispute: $19,877.89

Respondent's Position

"Regarding the disputed dates of service 12/20/2024 to 12/21/2024, the documentation submitted by the provider did not include a copy of the appeal previously submitted by the requestor. Review of the claim file and bill history confirms the provider did not submit an appeal to Texas Mutual upon receiving the first denial, therefore did not fully comply per Rule 133.307(J)... Our position is that no payment is due."

Response submitted by: Texas Mutual Insurance Co.

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 §133.250 sets out the procedures for reconsideration of a medical bill.
3. 28 TAC §134.404 sets out the acute care hospital fee guideline for inpatient services.

Denial Reasons

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

- 892 - BILL DOES NOT MEET 2 MIDNIGHT RULE REQUIREMENTS.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 892 - DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.
- 18 - EXACT DUPLICATE CLAIM/SERVICE.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 224 - DUPLICATE CHARGE.
- 877 - BILL PREVIOUSLY PROCESSED. REFER TO RULE 133.250 REGARDING REQUEST FOR RECONSIDERATION AND SUBMIT WITH ORIGINAL EOB AND CORRECTED BILL.

Issues

1. Are the disputed services eligible for review by Medical Fee Dispute Resolution (MFDR)?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the insurance carrier's reason for denial supported?
4. Is the requestor entitled to reimbursement?

Findings

1. In its position statement, the respondent asserts that the requestor did not submit an appeal or reconsideration request prior to its request for MFDR.

   The health care provider is permitted to file for medical fee dispute resolution only after it has

filed for reconsideration, per 28 TAC §133.250. The healthcare provider has 10 months from the date of service to request a reconsideration.

A review of the submitted explanation of benefits (EOB) document dated March 31, 2025, finds that the insurance carrier processed a reconsideration claim as is evidenced by remark code "193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY."

DWC finds that the disputed services are eligible for review by MFDR.

2. This dispute involves emergency room and inpatient hospital facility services rendered December 20, 2024, to December 21, 2024.

   DWC finds that 28 TAC §134.404 applies to the reimbursement of the services in dispute, which states in pertinent part, "(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section… (f) The reimbursement calculation used for establishing the maximum allowable reimbursement (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.

3. A review of the submitted EOBs find that the services in dispute were denied payment due to "Bill does not meet 2 midnight rule requirements."

   CMS Fact Sheet: Two-Midnight Rule references the November 13, 2015, Federal Register for the final rule on this topic. The Federal Register part 412.3 clarifies that an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights. The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The medical record must support the factors leading to the expectation that the patient will require hospital care that crosses two midnights.

   A review of the medical records and documentation submitted finds that the admitting physician's reasonable expectation of a two-midnight hospital stay is supported. Therefore, DWC finds that the insurance carrier's reason for denial of the disputed services based on the Medicare two midnight rule requirement is not supported.

4. The requestor is seeking reimbursement in the amount of $19,877.89 for emergency room and inpatient hospital facility services rendered December 20, 2024, through December 21, 2024. Because the insurance carrier's reason for denial is not supported, DWC will review the disputed services for reimbursement per the applicable fee guideline in accordance with 28 TAC §134.404.

   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 184. The service location is Lubbock, TX, Locality 99. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is $14,174.72. This amount multiplied by 143% results in a MAR of $20,269.85.

   Note that the "VBP adjustment" listed in the Medicare Inpatient PPS PC Pricer tool 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.

   The total MAR for the services in dispute is $20,269.85. The insurance carrier paid $0.00. The requestor is seeking $19,877.89 according to the submitted DWC060 MFDR request form. This amount of reimbursement is recommended.

   DWC finds that the requestor is entitled to reimbursement in the amount of $19,877.89 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 reimbursement in the amount of $19,877.89 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Texas Mutual Insurance Co. must remit to the University Medical Center $19,877.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 13, 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 electronico CompConnection@tdi.texas.gov.