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

Requester Name
Providence Memorial Hospital – East

Respondent Name
National American Insurance Co

MFDR Tracking Number
M4-25-2667-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
June 23, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 26, 2024 – August 2, 2024	111 MED-SUR-GY/PVT		$0.00
	250 PHARMACY		$0.00
	278 SUPPLY IMPLANTS		$0.00
	300 LABORATORY OR LAB		$0.00
	320 DX X-RAY		$0.00
	350 CTSCAN		$0.00
	360 OR SERVICES		$0.00
	370 ANESTHESIA		$0.00
	391 BLOOD/ADMIN		$0.00
	399 BLOOD/ADMINISTOR/OTHER		$0.00
	420 PHYSICAL THERP		$0.00
	424 PHYS THERP/EVAL		$0.00
	430 OCCUPATION THER		$0.00
	710 RECOVERY ROOM		$0.00
	730 EKG/ECG		$0.00
	922 EMG		$0.00
	Total	$14,551.29	$0.00

Requester's Position

"Please consider this letter to be written notice of Hospitals of Providence - East's formal dispute and appeal of the failure to make full payment for medically necessary services provided to the above-referenced patient under the terms of the plan and applicable law."

Amount in Dispute: $14,551.29

Respondent's Position

"The HCP was reimbursed according to the rule outlined above. Based on the DRG, ICD10 Diagnosis and ICD10 Procedure codes billed, CMS allows $44,064.50 -per the Web Pricer. As the HCP did not request separate reimbursement for implants, $44,064.50 is multiplied by the INPATIENT percentage of 143% which equals – $63,012.24 the amount paid to the provider. Check #5044228 was mailed to the provider by the carrier (NAICO) on 10/7/2024."

Response Submitted by: CorVel Healthcare Corporation

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:

- P12 – Workers' compensation State Fee Schedule Adj.
- W3 – Appeal/Reconsideration
- B13 – Payment for service may have been previously paid.
- Note: Reconsideration of bill #..., No Add'l due, paying per DRG 454.

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 requester entitled to additional payment?

Findings

1. This dispute involves inpatient hospital facility services rendered from July 26, 2024, to August 2, 2024. The insurance carrier reduced the payment based on workers' compensation state fee schedule. To assess whether the insurance carrier's payment complies with the relevant rules and guidelines, the Division of Workers' Compensation (DWC) will apply Rule 28 TAC §134.404.

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) by 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.

   Note: 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.

   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 454. The service location is El Paso, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $43,745.04. This amount multiplied by 143% results in a MAR of $62,555.41.

2. The total recommended payment for the services in dispute is $62,555.41. The insurance carrier paid $63,012.24. The insurance carrier paid the MAR amount, as a result, additional payment is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 $0.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 additional reimbursement for the disputed service.

Authorized Signature

		August 26, 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.