TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Fort Worth

Respondent Name
Sentry Casualty Co

MFDR Tracking Number
M4-16-3235-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the applicable Texas fee schedule the correct allowable would be per the DRG 028. The allowable for this DRG per Medicare is $32,638.06… The correct allowable would be at 143% making the allowable at $46,672.42. …there is an additional $3,771.61, still due at this time."

Amount in Dispute: $3,771.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The providers billing has the discharge status of 62 which is a Transfer case. …a reimbursement of $30,001.63. Then the markup of 143% for TX would recommend the reimbursement of $42902.33."

Response Submitted by: Sentry Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 24 – July 1, 2015	Inpatient hospital services	$3,771.81	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

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.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - (P12) Workers' compensation jurisdictional fee schedule adjustment
   - (94) Processed in excess of charges
   - (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - (193) Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - (16) Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

Issues

1. Is the insurance carrier's position supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. The insurance carrier states in their position statement in pertinent part the injured worker was transferred from TX Health Fort Worth to Texas Rehab of Fort Worth, which supports the payment for the transfer DRG.

   Review of the submitted medical bill found the submitted medical bill contains "62" in box 17 indicating the injured worker was transferred from the inpatient stay. The insurance carriers' position is supported the service in dispute will be reviewed per the applicable Medicare pricing policy in regards to transfers.

2. This dispute regards inpatient hospital facility services with payment subject to 28 Texas Administrative Code §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.

   Separate reimbursement for implantables was not requested; accordingly, Rule §134.404(f)(1)(A) requires the Medicare facility specific amount, including any outlier payment, be multiplied by 143%.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 028. The service location is Fort Worth, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $30,001.63. This amount multiplied by 143% results in a MAR of $42,902.33.

3. The total recommended payment for the services in dispute is $42,902.33. The insurance carrier paid $42,900.81. No additional payment is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		March 9, 2021
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 in accordance with Rule §133.307.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the form's instructions. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division, using the contact information on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.