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
USMD HOSPITAL ARLINGTON

Respondent Name
TRAVELERS CASUALTY & SURETY COMPANY

MFDR Tracking Number
M4-19-3595-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
March 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "How was it denied as a duplicate the very next day if they never received the first one? I believe the first original bill was received timely and mishandled in their scanning intake department."

Amount in Dispute: $47,079.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider is entitled to reimbursement for the disputed services. Reimbursement is being issued in accordance with the Texas Workers' Compensation Act & adopted Rules of the Division of Workers' compensation."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 30, 2018 to November 1, 2018	Inpatient Hospital Services	$47,079.53	$6,014.59

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 hospital facility fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – EXACT DUPLICATE CLAIM/SERVICE.
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 4271 – PER TX LABOR CODE SEC. 413.016, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional payment?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 4271 – PER TX LABOR CODE SEC. 413.016, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE.

   In their response to the MFDR request, the insurance carrier states, "the Provider is entitled to reimbursement for the disputed services. Reimbursement is being issued in accordance with the Texas Workers' Compensation Act & adopted Rules of the Division of Workers' compensation."

   Because the carrier has not maintained the above denial reasons in their MFDR response, the division concludes these denial reasons are not supported. Accordingly, the disputed services will be considered for reimbursement in accordance with division fee guidelines.

2. This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404, 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 with modifications set out in the rule. Medicare IPPS formulas and factors are available from http://www.cms.gov. For these services, Rule §134.404(f)(1)(A) requires 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 473. The service location is Arlington, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $13,987.43. This amount multiplied by 143% results in a MAR of $20,002.02.

   The total recommended payment for the disputed services is $20,002.02. The insurance carrier paid $13,987.43. The amount due is $6,014.59. This amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $6,014.59.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $6,014.59, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	May 2, 2019 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.