TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
UT Health Tyler

**Respondent Name**
Indemnity Insurance Co of North America

**MFDR Tracking Number**
M4-21-0665-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
December 16, 2020

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary**: "This inpatient bill and appeal have been underpaid."

**Amount in Dispute**: $3,189.60

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary**: "Our bill audit company has determined no further payment is due."

**Response Submitted by**: Gallagher Bassett

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| June 10 through July 17, 2020 | Inpatient hospital services | $3,189.60 | $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:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 70 – Cost outlier amount.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier (**Not** maintained upon Reconsideration).
   - 213 – Non-compliance with the physician self referral prohibition legislation or payer policy (**Not** maintained upon Reconsideration).

**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 regards inpatient hospital facility services. The requestor states in their position, "This inpatient bill and appeal have been underpaid." The applicable fee guideline is found in 28 TAC §134.404 (f) which states in pertinent part the maximum allowable reimbursement (MAR) is 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.

   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.

   Separate reimbursement for implantables was not requested; accordingly, Rule §134.404(f)(1)(A) requires that, for these services, 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 901. The service location is Tyler, TX. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $42,102.20. This amount multiplied by 143% results in a MAR of $60,206.15.

2. The total recommended payment for the services in dispute is $62,206.15. The insurance carrier has paid $60,206.15. 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

| | | |
|---|---|---|
| | | February 1, 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.