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
Baylor Orthopedic & Spine Hospital

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-21-1084-01

Carrier's Austin Representative
Box 15

MFDR Date Received
March 3, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement was submitted by the health care provider.

Amount in Dispute: $93,119.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Ace American Insurance Co is Downs Stanford who was notified of this medical fee dispute on March 9, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. This decision is based on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 25 – 26. 2020	Inpatient Hospital Services	$93,119.86	$21,017.90

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:
   - 146 – Diagnosis code is invalid for the date of service reported

Issues

1. Is the insurance carriers' denial 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 denied the disputed service based on the validity of the submitted diagnosis code, [redacted] Review of the ICD10 found this code is valid and further review found this is the diagnosis listed on the Utilization Review Approval dated July 24, 2020. The insurance carriers' denial is not supported. The service in dispute will be reviewed per applicable fee guidelines.
2. This dispute regards inpatient hospital facility services with payment subject to 28 TAC §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.

   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 implants was not requested. 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 [redacted]. The service location is Arlington, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $14,697.83. This amount multiplied by 143% results in a MAR of $21,017.90.
3. The total recommended payment for the services in dispute is $21,017.90.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $21,017.90.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $21,017.90, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 11, 2021 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.