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

Requestor Name
UT HEALTH TYLER

Respondent Name
INSURANCE CO OF THE STATE OF P

MFDR Tracking Number
M4-21-2220-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 02, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 28, 2020	Inpatient Hospital Service	$24,403.70	$0.00
	Total	$24,403.70	$0.00

Requestor's Position

"996 – Incorrect DRG Rate. The DRG Rate is $113.424.15 AND TEXAS HAS AN UPLIFT OF 143%.

REIMBURSEMNT SHOULD BE $162.196.53. PLEASE REVIEW FOR ADDITIONAL PAYMENT."

Amount in Dispute: $24,403.70

Respondent's Position

"It is the carrier's position that the reimbursement identified on the carrier's May 2, 2021 EOB is the amount that the provider is owed. The provider is not entitled to any additional reimbursement. The carrier's second EOB recommended zero additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

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 §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.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 00223 – WORKERS COMPENSATION JURISDICIONAL FEE SCHEDULE ADJUSTMENT
- 5280 – BILL QUALIFIES FOR FORESIGHT REVIEW
- 5721 – TO AVOID DUPLICATE BILL DENIAL FOR ALL RECONSIDERATION/ADJUSTMENTS/ADDITIONAL PAYMENT REQUESTS SBMIT A COPY OF THIS EOR OR CLEAR NOTATION
- 5969 – CV PROCESSOR READY TO RESOLVE ULES
- P12 – WORKERS COMPENSATION JURISIDCITONAL FEE SCHEDULE ADJUSTMENT
- 4886 – PAYMENT MADE PER MEDICARE'S IPPS METHODOLOGY, WITH THE APPLICABLE STATE MARKUP

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?

2. What is the recommended payment for the services in dispute?

3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states that:

   The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient

Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason, the MAR is calculated according to §134.404(f)(1)(A)

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 003. The services were provided at UTHEALTH TYLER. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $96,357.10. This amount multiplied by 143% results in a MAR of $137,790.65

3. The total allowable reimbursement for the services in dispute is $137,790.65. The amount previously paid by the insurance carrier is $137,792.83. No additional reimbursement can be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

[redacted]	[redacted]	September 2, 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 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.