

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

METHODIST SOUTHLAKE
MEDICAL

Respondent Name

TRAVELERS INDEMNITY CO

MFDR Tracking Number

M4-22-1819-01

Carrier's Austin Representative

Box Number 05

DWC Date Received

April 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 23, 2021 to August 30, 2021	Inpatient Hospital Services	\$7,255.73	\$0.00
Total		\$7,255.73	\$0.00

Requestor's Position

"This Request for Reconsideration of adjusted and/or disputed amounts is due to:

996 – Incorrect DRG Rate . Please see the CMS PC Pricer results for proper calculation.

1312 – Underpaid/Denied uncompensated Care. Please see the CMS PC Pricer results for proper calculation."

Amount in Dispute: \$7,255.73

Respondent's Position

"The Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

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 TAC §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 reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment
- W3 – Bill is a reconsideration or appeal

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 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 455. The service location is Southlake, TX. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$29,983.99. This amount multiplied by 143% results in a MAR of \$42,877.11.

2. The total allowable reimbursement for the services in dispute is \$42,877.11. The amount previously paid by the insurance carrier is \$42,896.45. 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



Signature



Medical Fee Dispute Resolution Officer

May 17, 2022

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 electrónico CompConnection@tdi.texas.gov.