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
METDALSPL LLC

Respondent Name
DALLAS COUNTY

MFDR Tracking Number
M4-22-1829-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
April 26, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14, 2021	Inpatient Hospital Service	$10,877.54	$0.00
	Total	$10,877.54	$0.00

Requestor's Position

According to TX workers compensation fee schedule the expected reimbursement for DOS 6/14/2021 is $27,819.79. Please note that implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $16,942.23.

Amount in Dispute: $10,877.54

Respondent's Position

The previous review is being maintained (Payment of $16942.23) and no additional allowance is recommended as the Payment Adjuster Factor was applied in accordance with the DWC guidelines.

Response submitted by: TASB Risk Fund

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 TAC §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:

- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculator
- 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
- 95 – Plan procedures not followed
- P12 – Workers Compensation Jurisdictional Fee Schedule adjustment
- U00 – There was no UR procedure/treatment request received
- 152 – Claim/service adjusted because the attachment referenced on the claim was not received in a timely fashion
- 164 – Attachment/other documentation referenced on the claim was not received in a timely fashion
- 305 – The implant is included in this billing is reimbursed at the higher percentage calculation
- 350 – Bill has been identified as a request for reconsideration or appeal
- 375 – Please see special *NOTE* BELOW
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for 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 in accordance with 28 TAC 134.404(g)(1). 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 470. The service location is Addison, TX. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $11,847.71. This amount multiplied by 143% results in a MAR of $16,942.23.

2. The total allowable reimbursement for the services in dispute is $16,942.23. The amount previously paid by the insurance carrier is $16,942.23. 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]

Signature	[redacted] Medical Fee Dispute Resolution Officer	June 29, 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 electronico CompConnection@tdi.texas.gov.