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**
Odessa Regional Medical Center

**Respondent Name**
Starr Indemnity & Liability Co

**MFDR Tracking Number**
M4-22-1950-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
April 28, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| October 8, 2021 | Emergency Visit and Inpatient Stay Procedure | $488.80 | $478.56 |
| | **Total** | $488.80 | $478.56 |

## Requestor's Position

JThe initial bill was fir timely filing. The appeal with proof of timely was underpaid.

**Amount in Dispute:** $488.80

## Respondent's Position

"This dispute involves an emergency room visit and inpatient stay with dates of service of 10/08/2021 with an amount originally billed at $91,1042.94. The bill was reduced to $23,976.87 and paid. The provider seeks an additional $4888.80. The carrier's position remains consistent with its EOB."

**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 TAC §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 original denial of untimely claim submission was not upheld. Upon reconsideration, the insurance carrier paid the disputed charges. Neither party submitted an explanation of benefits detailing the payment of the disputed charges.

## 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 629. The service location is Odessa, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $17,101.70. This amount multiplied by 143% results in a MAR of $24,455.43.

2. The total recommended payment for the services in dispute is $24,455.43. The insurance carrier has paid $23,976.87. The remaining balance of $478.56 is due to the requestor.

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 established that additional reimbursement {of $478.56 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. {It is ordered that Starr Indemnity & Liability Co must remit to Odessa Regional Medical Center $478.56 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

Authorized Signature

| | | |
|---|---|---|
| | | June 10, 2022 |
| 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.