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
Crescent Medical Center

Respondent Name
Peerless Insurance

MFDR Tracking Number
M4-24-0118-01

Carrier's Austin Representative
Box Number **60**

DWC Date Received
September 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14 – 19, 2023	Rev 0278	$12,891.76	$0.00
June 14 – 19, 2023	DRG 455	-$9,423.79	$0.00
		$3,467.97	$0.00

Requestor's Position

"We are requesting the MAR value of $52,255.55. Please pay the additional $3467.97."

Amount in Dispute: $3,467.97

Respondent's Position

"...Texas Administrative Code Tile 28 that advises implants should be requested in box 80 of the UB-04 billing form. Implant reimbursement was requested in box 43..."

Response Submitted by: Liberty Mutual

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.10 sets out required billing forms/formats of medical bills.
3. 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:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup.

Issues

1. Is the respondent's position 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 requestor is seeking additional payment for Revenue Code 278 (Implants) for an inpatient surgery rendered in June of 2023. The insurance carrier states the request for implants did not comply with the requirements of DWC Rule 28 TAC 133.10 (f)(2)(QQ) which states, "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."

   Review of the submitted medical bill found field 80 was blank. The insurance carrier's position is supported. The date of service will be reviewed per applicable fee guideline when separate reimbursement for implants is not requested.

2. The maximum allowable reimbursement (MAR) for inpatient hospital facility services must comply with DWC Rule 28 TAC 134.404(f), which requires that it must be the Medicare facility-specific amount (including outlier payments) using the Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, as published annually in the Federal Register, with any modifications outlined in the rules. The Centers for Medicare and Medicaid Services can be reached at http://www.cms.gov for information on the Medicare IPPS formula and

factors. 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 per requirements of DWC Rule 28 TAC §133.10. DWC Rule 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 CMS Zip Code Locator indicates the service location is 11 (Dallas). Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $34,115.73. This amount multiplied by 143% results in a MAR of $48,785.49.

3. The total recommended payment for the services in dispute is $48,785.49. The insurance carrier has paid $48,787.58. Additional payment is not 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		November 7, 2023
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.