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
Providence Sierra

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-24-0161-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 18, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 7 -19, 2022	0111	$57,396.00	$0.00
September 7 -19, 2022	0250	$35,903.27	$0.00
September 7 -19, 2022	0272	$2,468.00	$0.00
September 7 -19, 2022	0278	$45,107.36	$0.00
September 7 -19, 2022	0300	$26,740.00	$0.00
September 7 -19, 2022	0320	$2,546.00	$0.00
September 7 -19, 2022	0360	$63,136.00	$14,073.86
September 7 -19, 2022	0370	$9,440.00	$0.00
September 7 -19, 2022	0410	$12,310.00	$0.00
September 7 -19, 2022	0420	$4,605.00	$0.00
September 7 -19, 2022	0424	$3,187.00	$0.00
September 7 -19, 2022	0430	$5,918.00	$0.00
September 7 -19, 2022	0610	$6,229.00	$0.00
September 7 -19, 2022	0710	$6,610.00	$0.00
September 7 -19, 2022	0730	$854.00	$0.00
WC ADJUSTMENTS	WC ADJUSTMENTS	-268,837.77	$0.00
	Total	$14,073.86	$14,073.86

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Sedgwick, but the bill was denied. However, despite the Hospital's efforts and Request for Reconsideration Sedgwick has not rendered proper payment."

Amount in Dispute: $14,073.86

Respondent's Position

"It remains the carrier's position that the provider is not entitled to reimbursement because the provider did not timely submit its medical bill to the carrier."

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).

Statues and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets out requirements of medical bill submission.
3. 28 TAC §134.404 sets out the acute care hospital fee guideline for inpatient services.

Denial Reasons

The insurance carrier denied the disputed services with the following claim adjustment codes.

- 29 – The time limit for filing claim/bill has expired.
- 4271 – Per TX Labor Code Sec 408.027, Providers must submit bills to payors within 95 days of the date of service.

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is the requestor due payment?

Findings

1. The requestor is seeking reimbursement for inpatient hospital services with an admission date of September 7, 2022 and discharge date of September 19, 2022.

   The submitted explanation of benefits indicates the claim was first received by the vendor on December 20, 2022. This date of receipt is prior to the 95th day from the date of discharge. The insurance carrier's denial is not supported. The service in dispute will be reviewed per the applicable fee guidelines.

2. This dispute regards inpatient hospital facility services with payment subject to DWC Rule 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. 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 902. The service location is El Paso, Texas. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is $13,031.34. This amount multiplied by 143% results in a MAR of $18,634.72.

3. The total recommended payment for the services in dispute is $18,634.82. The requestor is seeking $14,073.86. This amount is 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 established that additional reimbursement 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 New Hampshire Insurance Co must remit to Providence Sierra $14,073.86 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 23 , 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.