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**
Texas Health Fort Worth

**Respondent Name**
Arch Insurance Co

**MFDR Tracking Number**
M4-24-0684-01

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

**DWC Date Received**
November 20, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | Left Blank | Left Blank | $0.00 |
| May 11, 2023 | 0306 | Left Blank | $0.00 |
| May 11, 2023 | 0309 | Left Blank | $0.00 |
| May 11, 2023 | 0312 | Left Blank | $0.00 |
| May 11, 2023 | 0320 | Left Blank | $0.00 |
| May 11, 2023 | 0350 | Left Blank | $0.00 |
| May 11, 2023 | 0360 | Left Blank | $0.00 |
| May 11, 2023 | 0370 | Left Blank | $0.00 |
| May 11, 2023 | 0420 | Left Blank | $0.00 |
| May 11, 2023 | 0424 | Left Blank | $0.00 |
| May 11, 2023 | 0430 | Left Blank | $0.00 |
| May 11, 2023 | 0434 | Left Blank | $0.00 |

| | | | |
|---|---|---|---|
| May 11, 2023 | 0636 | Left Blank | $0.00 |
| May 11, 2023 | 0710 | Left Blank | $0.00 |
| | **Total** | $7,055.14 | $0.00 |

## Requestor's Position

"Attached is a copy of a DWC-060 Form, EOB, UB04, an itemized statement, a copy of an appeal letter, a Medicare calculation worksheet from WEBPRICER.CMS.GOV, and medical records. The claim referenced below was billed as an inpatient visit, and the Medicare reimbursement is $21,936.71. The work comp reimbursement should be $21,936.71 (15,340.36 X 143%), however, we have received a partial payment of $5,105.53 from Sedgwick CMS. We requested a review of the payment, and the reconsideration/appeal was denied."

**Amount in Dispute:** $7,055.14

## Respondent's Position

"Our Fee Schedule team has determined that the provider is not due any additional allowance."

**Supplemental response submitted December 27, 2023**

"Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bills in question were escalated and a review completed. Our bill audit company has determined no further payment is due."

**Response Submitted by:** Gallager Bassett

## 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 §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.
- 16 – Claim/service lacks information or has submission/billing error (s) which is needed for adjudication.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

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 rendered in May of 2023 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 571. The service location is Fort Worth, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $14,749.90. This amount multiplied by 143% results in a MAR of $21,092.36.
2. The total recommended payment for the services in dispute is $21,092.36. The insurance carrier has paid $21,093.07. No additional payment 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 not established that additional reimbursement $7,055.14 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**

| | | |
|---|---|---|
| | | January 10, 2024 |
| 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.