



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

USMD Hospital at
Arlington

Respondent Name

Merged into TIG Ins Co-Fairmont Premier

MFDR Tracking Number

M4-24-0866-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

December 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 1 – 3, 2023	DRG 455	\$158,653.43	\$25,719.40
Total		\$158,653.43	\$25,719.40

Requestor's Position

"The insurance carrier first requested USMD to settle the account for \$8500.00, Then requested USMD to settle the account for \$12500.00. Both times we instructed them that we would not accept worker's compensation payment less than what is allowed in the worker's compensation inpatient fee schedule."

Amount in Dispute: \$158,653.43

Respondent's Position

"Upon receipt of the MFDR, Zenith identified that the original bill was underpaid. Additional Payment Recommended \$25,153.76. Zenith will wait to receive the MFDR Decision to process the additional payment."

Response Submitted by: The Zenith

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:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.
- N45 – Payment based on authorized amount.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on Workers' compensation jurisdictional regulations or payment policies.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – TX Bill has been identified as a request for reconsideration or appeal.
- 790 – TX This charge was reimbursed in accordance to the Texas Medical Fee Guidelines.
- 18 – Exact Duplicate Claim/Service.

Issues

1. Are the insurance carrier's payment reductions 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 disputed services were reduced in part by the carrier as "45 charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement" and "N130 consult plan benefit documents/guidelines"

Review of the information known to the Division regarding this dispute found insufficient evidence to support a contract between the two parties, or mutually agreed authorized amount. The reductions are not supported. Additionally, the requestor states that they expect payment of "what is allowed in the worker's compensation inpatient fee schedule." The maximum allowable reimbursement (MAR) for this dispute is calculated per the applicable DWC fee guideline shown below.

2. This dispute regards inpatient hospital facility services rendered in August 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 455. The service location is Arlington, Texas. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$31,064.68. This amount multiplied by 143% results in a MAR of \$44,422.49.

3. The total recommended payment for the services in dispute is \$44,422.49. The insurance carrier paid \$18,703.09. The requestor is entitled to an additional payment of \$25,719.40. 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 requestor has established that additional reimbursement of \$25,719.40 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 Merged into TIG Ins Co-Fairmont Premier Insurance must remit to USMD Hospital @ Arlington \$25,719.40 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 14, 2024
Date

Signature

Director of Medical Fee Dispute Resolution

March 14, 2024
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 prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.