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
AIU Insurance

MFDR Tracking Number
M4-24-0919-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 7, 2023	111	Left blank	All-inclusive see below
July 7, 2023	250	Left blank	All-inclusive see below
July 7, 2023	258	Left blank	All-inclusive see below
July 7, 2023	272	Left blank	All-inclusive see below
July 7, 2023	300	Left blank	All-inclusive see below
July 7, 2023	301	Left blank	All-inclusive see below
July 7, 2023	302	Left blank	All-inclusive see below
July 7, 2023	305	Left blank	All-inclusive see below
July 7, 2023	306	Left blank	All-inclusive see below
July 7, 2023	320	Left blank	All-inclusive see below
July 7, 2023	450	Left blank	All-inclusive see below
July 7, 2023	636	Left blank	All-inclusive see below

July 7, 2023	730	Left blank	All-inclusive see below
	Total	$14,489.86	$11,628.22

Requestor's Position

"The initial claim was sent electronically 8/14/2023/2023[sic], however this claim was denied "5050 CLAIM IS DENIED NO PAYMENT WILL BE MADE. Please review the attached information and reprocess our claim for payment due us for the services provided to the claimant."

Amount in Dispute: $14,489.86

Respondent's Position

The Austin carrier representative for AIU Insurance is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 3, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response Submitted by: N/A

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:

- 247 – A payment or denial has already been recommended for this service.
- 5050 – Claim is denied. No payment will be made.

Issues

1. Did the respondent support denial of the services per applicable DWC rule(s).
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. This dispute regards inpatient hospital facility services rendered in July 2023. The information known to the Division included the insurance carrier's denial for duplicate and the notification "Claim is denied – No payment will be made." These denials are not supported by a position statement by the respondent or a DWC Rule reference. The services in dispute will be reviewed per applicable fee guideline.
2. Inpatient hospital services payment is 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 603. The service location is Fort Worth, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $8,131.62. This amount multiplied by 143% results in a MAR of $11,628.22.
2. The total recommended payment for the services in dispute is $11,628.22. The insurance carrier has paid $0.00. A payment of $11,628.22 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 of $11,628.22 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 AIU Insurance Co must remit to Texas Health Fort Worth $11,628.22 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	April 30, 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 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.