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
University Medical Center

Respondent Name
Lubbock County

MFDR Tracking Number
M4-24-1223-01

Carrier's Austin Representative
Box Number 43

DWC Date Received
January 31, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 1-4, 2023	120/DRG 494	$6,615.99	$6,615.99
	Total	$6,615.99	$6,615.99

Requestor's Position

"This is a bill for an inpatient stay from July 1, 2023 – July 4, 2023, and included medical/surgical supplies. Per https://webpricer.cms.gov/#/pricer/ipps this should pay $18,902.78 x 143% = $27,030.98. The Implants were NOT requested to be paid separately. The carrier originally paid $20,414.99. …There is a balance left of $6615.99, this is the amount we are seeking for medical dispute."

Amount in Dispute: $6,615.99

Respondent's Position

The Austin carrier representative for Lubbock County is Sedwick York Risk Services Group. The representative was notified of this medical fee dispute on February 6, 2024,

Per 28 TAC §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:

- 4896 – Payment made per Medicare's IPPS Methodology, with the applicable state markup.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- P1 – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patient's responsibility, unless the workers compensation state law allows the patient to be billed.

- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.

Issues

1. Did the requestor seek separate reimbursement of implants?
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 insurance carrier denied Revenue Code 278 for lacking information and an attachment required to adjudicate the claim/service.

   DWC Rule 28 TAC §133.10 (f)(2)(QQ) states in pertinent parts, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

   > (2) The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care:
   >
   > (QQ) remarks (UB-04/field 80) are required when separate reimbursement for surgically implanted devices is requested.

   Review of the submitted medical bill found Box 80 did not contain a request for separate implant reimbursement. The insurance carrier's denial/reduction is not supported. The disputed service will be reviewed per applicable fee guideline.

2. The disputes services are 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 494. The service location is Lubbock, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $18,902.78. This amount multiplied by 143% results in a MAR of $27,030.98.

3. The total recommended payment for the services in dispute is $27,030.98. The insurance carrier has paid $20,414.99. The requestor is entitled to an additional payment of $6,615.99. 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 Lubbock County must remit to University Medical Center $6,615.99 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 19, 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, 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.