



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Tx Health Arlington

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-24-1571-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

March 18, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 25, 2023	0111	Left blank	\$0.00
September 25, 2023	0111	Left blank	\$4,185.11
September 25, 2023	0250	Left blank	\$0.00
September 25, 2023	0272	Left blank	\$0.00
September 25, 2023	0300	Left blank	\$0.00
September 25, 2023	0301	Left blank	\$0.00
September 25, 2023	0305	Left blank	\$0.00
September 25, 2023	0306	Left blank	\$0.00
September 25, 2023	0307	Left blank	\$0.00
September 25, 2023	0309	Left blank	\$0.00
Left blank	0320	Left blank	\$0.00
Left blank	0350	Left blank	\$0.00
Left blank	0351	Left blank	\$0.00
Left blank	0390	Left blank	\$0.00
Left blank	0420	Left blank	\$0.00
Left blank	0424	Left blank	\$0.00
Left blank	0450	Left blank	\$0.00
Left blank	0636	Left blank	\$0.00
Left blank	0730	Left blank	\$0.00
Left blank	0761	Left blank	\$0.00
Total		\$4240.03	\$4,185.11

Requestor's Position

"The claim referenced below was billed an inpatient visit, and the Medicare reimbursement is \$17,322.03. The work comp reimbursement should be \$17,322.03 (12,113.31 X 143%), however, we have received a partial payment of \$13,082.00 from Sedgwick CMS. We requested a review of the payment, and the reconsideration/appeal was denied."

Amount in Dispute: \$4,240.03

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North America is Downs & Stanford. The representative was notified of this medical fee dispute on March 26, 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:

- BT100 – Unless otherwise specified, services have been reviewed to the State Fee Schedule.
- TXP 12 – Workers' compensation jurisdictional fee schedule adjustment.
- BT975 – No additional allowance is recommended.
- TX193 – Original payment decision is being maintained. Upon review, it was

determined that this claim was processed properly.

Issues

1. Is the respondent's reduction in payment supported?
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 from September 25, 2023 to October 3, 2023. The insurance carrier reduced the payment based on workers compensation fee schedule.

The disputed services will be reviewed per applicable fee guideline shown below.

2. The payment of inpatient hospital services is subject to DWC Rule 28 TAC §134.404(f), that requires 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>.

Note: the "VBP adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system. However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system. Rule §134.404(d)(1) requires that specific Labor Code provisions and division rules take precedence over conflicting CMS provisions for administering Medicare. Consequently, VBP adjustments are not considered in determining the facility reimbursement.

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 811. The service location is Arlington, TX. Based on DRG code, service location, and bill-specific information (i.e. transfer status 62 discharged to IRF), the Medicare facility specific amount is 12,112.97 (less VBP adjustment \$38.07) = \$12,074.90. This amount multiplied by 143% results in a MAR of \$17,267.11.

2. The total recommended payment for the services in dispute is \$17,267.11. The insurance carrier paid \$13,082.00. The requestor is entitled to an additional payment of \$4,185.11. 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 of \$4,185.11 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 Indemnity Insurance Co of North America must remit to TX Health Arlington \$4,185.11 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	Date

May 16, 2024

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 electrónico CompConnection@tdi.texas.gov.