



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Metdalspl LLC

**Respondent Name**

Travelers Indemnity Co

**MFDR Tracking Number**

M4-24-2286-01

**Carrier's Austin Representative**

Box Number 05

**DWC Date Received**

June 17, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 5, 2023	Inpatient Stay	\$557.90	\$0.00
<b>Total</b>		\$557.90	\$0.00

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated May 31, 2024, that states, "In accordance to the worker compensation guidelines the invoice should be processed and paid per the IPPS Pricer Calculations for the DRG time 143%."

**Amount in Dispute:** \$557.90

### Respondent's Position

"The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated."

**Response Submitted by:** Travelers

## 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:

- 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 29 – The time limit for filing has expired.
- 5740 – The bill service is under a Paradigm contract.
- 4271 – Per TX Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- W1 - Workers' compensation jurisdictional fee schedule adjustment.
- B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 687 – This service was priced according to the Medicare transfer policy under the Inpatient Prospective Payment System.
- 779 – Reimbursement for your submitted invoice has been considered, additional monies are not being paid at this time.
- 18 – Exact duplicate claim/service.
- 223 – Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.

### 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 in July of 2023 when the insurance carrier reduced the payment based on workers' compensation fee guideline, Medicare

transfer policy and Paradigm contract. The denials for claim are not sent to correct payer and untimely filing. A review of the submitted documentation found insufficient evidence to support a contract that exists between the two parties. The disputed services will be reviewed per applicable fee guideline.

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>.

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](http://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 519. The services were provided in Addison, Texas. The post-acute transfer status (06) was indicated in box 17 of submitted medical bill. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$12,075.51. This amount multiplied by 143% results in a MAR of \$17,267.98.

2. The total recommended payment for the services in dispute is \$17, 267.98. The insurance carrier paid \$17,266.19. 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 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

July 18, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).