



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

University Medical Center

**Respondent Name**

Lubbock County

**MFDR Tracking Number**

M4-24-2289-01

**Carrier's Austin Representative**

Box Number 43

**DWC Date Received**

June 17, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 14 – 16, 2023	Inpatient Stay	\$603.07	\$603.07
<b>Total</b>		\$603.07	\$603.07

### Requestor's Position

"The DRG code of 493 has a payable rate of \$22770.44 x 143% = \$32561.73. The carrier paid \$31958.66 leaving a balance due of \$603.07."

**Amount in Dispute:** \$603.07

### Respondent's Position

The Austin carrier representative for Lubbock County is JI Specialty Services. The representative was notified of this medical fee dispute on June 25, 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.

## 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:

- 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.
- 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

### Issues

1. Is the respondent's reduction of 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 August 2023 the insurance carrier reduced the payment based on fee schedule adjustment. The maximum allowable reimbursement is 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>.

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 493. The service location is Lubbock, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$22,770.44. This amount multiplied by 143% results in a MAR of \$32,561.73.

2. The total recommended payment for the services in dispute is \$32,561.73. The insurance carrier paid \$31,958.66. The requestor is entitled to an additional payment of \$603.07. 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 \$603.07 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

_____	_____	September 24, 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](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).