



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Health of Ft. Worth

Respondent Name

Great American Alliance Insurance Co.

MFDR Tracking Number

M4-24-2896-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 7, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 21, 2023, to September 23, 2023	Inpatient Hospital Services DRG 514	\$3,043.14	\$3,043.14
Total		\$3,043.14	\$3,043.14

Requestor's Position

"The initial claim was sent electronically 10/20/2023 and paid \$ 10,024.56 a reconsideration was sent 11/29/2023 and 2/21/2024 and 4/10/2024, per EOR, B13 'PREVIOUSLY PAID' which leaves a remaining balance of \$3,043.14. Please review the attached information and reprocess our claim for the additional payment due us for the services provided to the claimant. "

Amount in Dispute: \$3,043.14

Respondent's Position

"This dispute involves a date of service of 09/21/2023 with an amount originally billed at \$36,930.82. The bill was reduced to \$10,024.56 and paid. The carrier's position remains consistent with its EOB."

Response submitted by: Flahive, Ogden & Latson

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.

Adjustment or Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 468 – PRICING IS BASED ON THE MEDICAL HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM METHODOLOGY.
- W3 & 350 – THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- Q01 – ADDITIONAL ALLOWANCE RECOMMENDED. THIS HAS BEEN RE-EVALUATED AND AN ADDITIONAL ALLOWANCE IS RECOMMENDED.
- 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S).
- 270 – TDI TITLE 28 CHAPTER 134.801 PROVIDERS ONLY HAVE 95 DAYS TO SUBMIT MEDICAL BILLS FOR PAYMENT FROM THE DATE OF SERVICE.

Issues

1. Is reason code 270 on the explanation of benefits (EOB) referring to the 95-day limit to submit a medical bill supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. A review of the EOBs submitted finds that reason code 270 cites the 95 days from date of service time limit to file a medical bill. DWC Rule 28 TAC §133.20, which sets out requirements of timely medical bill submission, states in pertinent part "(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

A review of the submitted documentation finds evidence to show that the requestor submitted the original claim on October 24, 2023, less than 95 days after the disputed dates of service. Furthermore, the insurance carrier made payment on the claim in question, indicating that the claim was received in a timely manner.

DWC finds that the requestor submitted the medical bill for the services in dispute in a timely manner in accordance with 28 TAC §133.20. Therefore, reason code 270 is not supported.

2. This dispute involves emergency room and inpatient hospital facility services rendered September 21, 2023, through September 23, 2023.

DWC finds that 28 TAC §134.404(f) applies to the maximum allowable reimbursement (MAR) of the services in dispute, which states in pertinent part, "(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 143 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at <http://www.cms.gov>.

2. The requestor is seeking additional reimbursement in the amount of \$3,043.14 for emergency room and inpatient hospital facility services rendered September 21, 2023, through September 23, 2023.

DWC 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%.

A review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 514. The service location is Ft. Worth, TX, Locality 28. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$9,270.36. This amount multiplied by 143% results in a MAR of \$13,256.61.

The total recommended payment for the services in dispute is \$13,256.61. The insurance carrier paid \$10,024.56. The difference between the MAR and the insurance carrier's previous reimbursement amount is \$3,232.05. The requestor is seeking an additional \$3,043.14; therefore, this amount is recommended.

DWC finds that the requestor is entitled to additional reimbursement in the amount of \$3,043.14 for the services in dispute.

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 requestor has established that additional reimbursement in the amount of \$3,043.14 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 Great American Alliance Insurance Co. must remit to Texas Health of Ft. Worth \$3,043.14 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	October 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. 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.