TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
University Medical Center

Respondent Name
Standard Fire Insurance Co.

MFDR Tracking Number
M4-25-0589-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
November 8, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 28, 2024 – February 29, 2024	Inpatient Hospital Services DRG 923 All Inclusive	$490.49	$490.49
	Total	$490.49	$490.49

Requestor's Position

"This is a bill for an in-patients stay February 28, 2024-February 29, 2024. Per https://webpricer.cms.gov/#/pricer/ipps this should pay $13,307.99 X 143% = $19,030.43. The carrier originally paid $18,539.94. We submitted an appeal for underpayment with the Medicare allowable that shows what the markup should be. The carrier did not pay any additional amount stating, upheld, no additional allowance has been recommended. There is a balance left of $490.49, this is the amount we are seeking for medical dispute."

Amount in Dispute: $490.49

Respondents' Position

"The Carrier has reviewed the documentation and contends the Provider has been appropriately reimbursed at the appropriate fee schedule reimbursement for the emergency room admission and the related services per the applicable Medicare edits. 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.

Adjustment Reasons

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

- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 4896 - PAYMENT MADE PER MEDICARE'S IPPS METHODOLOGY, WITH THE APPLICABLE STATE MARKUP.
- 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED.
- 2005 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional payment?

Findings

1. This dispute involves emergency room and inpatient hospital facility services rendered February 28, 2024, through February 29, 2024.

   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 $490.49 for emergency room and inpatient hospital facility services rendered February 28, 2024, through February 29, 2024.

   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 923. The service location is Lubbock, TX, Locality 99. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is $13,307.99. This amount multiplied by 143% results in a MAR of $19,030.43.

   The total recommended payment for the services in dispute is $19,030.43. The insurance carrier paid $18,539.94. DWC finds that the requestor is entitled to an additional payment of $490.49. 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 requestor has established that additional reimbursement in the amount of $490.49 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 Standard Fire Insurance Co. must remit to University Medical Center $490.49 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 8, 2025
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 electronico CompConnection@tdi.texas.gov.