



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

University Medical Center

**Respondent Name**

Amtrust Insurance Co.

**MFDR Tracking Number**

M4-25-1065-01

**Carrier's Austin Representative**

Box Number 17

**DWC Date Received**

January 21, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2024, to May 9, 2024	0120/DRG 467	\$2,816.48	\$2,816.48

### Requestor's Position

"This is a bill for an inpatient stay May 7, 2024- May 9, 2024, and included medical/surgical supplies. Per <https://webpricer.cms.gov/#/pricer/ippsService> this should pay \$33,970.70 X 143% = \$48,578.10. The Implants were NOT requested to be paid separate. The carrier originally paid \$45,761.62. 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. There is a balance left of \$2,816.48 this is the amount we are seeking for medical dispute. "

**Amount in Dispute:** \$2,816.48

### Respondent's Position

"Reimbursement was made pursuant to the inpatient prospective payment system. Further, implant reimbursement was included and was reimbursement at the higher percentage calculation. In conclusion, Requestor is not owed any additional reimbursement for the inpatient surgical admission from 5/07/2024-5/09/2024."

**Response submitted by:** Downs & Stanford, P.C.

## 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:

- 305 – THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
- 687 – THIS SERVICE WAS PRICED ACCORDING TO THE MEDICARE TRANSFER POLICY UNDER THE INPATIENT PROSPECTIVE PAYMENT SYSTEM.
- P12 & W1 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3 & 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804 THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

### 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 surgical inpatient hospital facility services rendered May 7, 2024, to May 9, 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 \$2,816.48 for surgery and inpatient hospital facility services rendered May 7, 2024, to May 9, 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](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%.

A review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 467. 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 \$33,970.70. This amount multiplied by 143% results in a MAR of \$48,578.10.

The total recommended payment for the services in dispute is \$48,578.10. The insurance carrier paid \$45,761.62. The difference between the MAR and the insurance carrier’s previous reimbursement amount is \$2,816.48. This amount of additional reimbursement is recommended.

DWC finds that the requestor is entitled to additional reimbursement in the amount of \$2,816.48 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 \$2,816.48 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 Amtrust Insurance Co. must remit to the University Medical Center \$2,816.48 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

\_\_\_\_\_  
March 28, 2025  
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).