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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
TEXAS SPINE AND JOINT HOSPITAL

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-22-0586-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 23, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2021	Outpatient Facility Charges	$15,218.56	$5,099.70
	Total	$15,218.56	$5,099.70

Requestor's Position

"…the bill was denied due to the surgery not being authorized. We appealed Sedgwick's decision, but the denial was upheld… our position is that Sedgwick's denial is incorrect because the attached documents clearly show authorization being provided. We have attempted to resolve this matter with Sedgwick's claims adjuster…"

Amount in Dispute: $15,218.56

Respondent's Position

"…condition was disputed as not being part of the compensable injury. We are attaching a copy of the carrier's PLN-11 dated May 28, 2021."

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403 sets out the outpatient hospital facility fee guidelines.

Denial Reasons

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

- 5264 – Payment is denied-service not authorized.
- 197 – Payment denied/reduced for absence of precertification/authorization.

Issues

1. Are there unresolved extent of injury issues?
2. Did the requestor obtain preauthorization for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for outpatient services rendered on May 24, 2021. Flahive, Ogden & Latson, on behalf of the insurance carrier argued that "**…**condition was disputed as not being part of the compensable injury. We are attaching a copy of the carrier's PLN-11 dated May 28, 2021."

   Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution.

   28 TAC §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including: a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider . . . related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

   Review of the submitted information finds insufficient documentation to support that an EOB containing a denial for extent of injury was presented to the health care provider giving notice of the new denial reasons or defenses raised in the insurance carrier's response to MFDR.

28 TAC §133.307(d)(2)(F) requires that:

> The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

Pursuant to 28 TAC §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by 28 TAC §133.240 finds that the insurance carrier's new defense presented on the position summary is therefore not supported.

Upon review of the insurance carrier response, the division finds the respondent has raised new denial reasons or defenses of which the carrier failed to give any notice to the health care provider during the medical bill review process or before the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise such new denial reasons or defenses during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

2. The insurance carrier denied/reduced the outpatient facility services with denial reduction code(s), 5264 and 197 (description provided above.)

   The requestor submitted a copy of a preauthorization letter dated, May 10, 2021 which preauthorized outpatient surgery with a start date of 5/10/2021 and end date o 8/31/2021. The outpatient surgery in dispute is dated May 24, 2021. The DWC finds that the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement for the service in dispute.

3. 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators.

   The DWC fee guideline based found in 28 TAC §134.403 and states when separate payment of implants is not requested, the Medicare facility specific amount will be multiplied by 200%. The calculation is found below.

   Review of the submitted medical bill finds the following:

   - Procedure code 29881 has status indicator J1, for procedures paid at a comprehensive rate. All line items on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5113.
   - The OPPS Addendum A rate is $2,830.40. This is multiplied by 60% for an unadjusted labor amount of $1,698.24, in turn multiplied by facility wage index 0.8348 for an adjusted labor amount of $1,417.69.
   - The non-labor portion is 40% of the APC rate, or $1,132.16.
   - The sum of the labor and non-labor portions is $2,549.85.

The Medicare facility specific amount is $2,549.85 multiplied by 200% for a MAR of $5,099.70. The insurance carrier reimbursed the requestor $0.00 as a result the requestor is entitled to a reimbursement amount of $5,099.70.

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.

The DWC finds the requester has established that reimbursement of $5,099.70 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $5,099.70 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

______________________	______________________	January 27, 2022
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.