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

General Information

Requestor Name
Houston Methodist Hospital

Respondent Name
Carolina Casualty Insurance Co

MFDR Tracking Number
M4-23-2351-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 18, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 8 -9, 2022	250	$0.00	$0.00
December 8 -9, 2022	276	$0.00	$0.00
December 8 -9, 2022	278	$0.00	$0.00
December 8 -9, 2022	300	$0.00	$0.00
December 8 -9, 2022	301	$0.00	$0.00
December 8 -9, 2022	305	$0.00	$0.00
December 8 -9, 2022	310	$0.00	$0.00
December 8 -9, 2022	320	$0.00	$0.00
December 8 -9, 2022	360	$5333.50	$5333.50
December 8 -9, 2022	370	$0.00	$0.00
December 8 -9, 2022	636	$0.00	$0.00
December 8 -9, 2022	710	$0.00	$0.00
	Total	$5333.50	$5333.50

Requestor's Position

"This bill is for an outpatient surgery that should pay per TDI rule 134.403. The carrier processed an original bill and paid a total of $6283.35. We submitted an appeal due to this audit company Mitchell Bill review continues to request implant invoices to process the charges. …Implant invoices are not required unless the Provider request separate reimbursement and submits certified invoices."

Amount in Dispute: $5333.50

Respondent's Position

The Austin carrier representative for Carolina Casualty is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on May 23, 2023.

Per 28 Texas Administrative Code(TAC) §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 §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

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

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated arrangement

- W3 – In accordance with the TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

- 350 – Bill has been identified as a request for reconsideration or appeal

- 131 – Claim specific negotiated discount
- P11 – Allowance was reduced as per contractual agreement
- 134 – Claim specific negotiated discount
- 16 – Claim/service lacks information or has submission-billing errors
- 225 – The submitted documentation does not support the service being billed. We will reevaluate this upon receipt of clarifying information
- 252 – An attachment or other documentation is required to adjudicate this claim/service
- 253 – In order to review this charge please submit a copy of the certified invoice
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Did the respondent support a negotiated contract rate?
2. Did the requestor seek separate reimbursement of implants?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to additional reimbursement?

Findings

1. The explanation of benefits submitted with this request for MFDR indicated 131- claim specific negotiated discount and P-11 - Allowance was reduced as per contractual agreement. Also indicated was a PPO reduction of $2,094.45.

   Insufficient evidence was found to support whether the injured employee was enrolled in a certified network or that a contract or negotiated discount exists. These denials are not supported and will not be considered in this review.

2. The requestor is seeking additional reimbursement for outpatient hospital services, revenue code 360 rendered December of 2022. The insurance carrier reduced the charges based on lack of certified invoice for implants. DWC Rule 28 TAC §134.403(f)(1)(A)(B) states in pertinent part, The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment shall be multiplied by 200 percent; unless a facility or surgical provider request separate reimbursement in accordance with subsection (g)…

   A review of the submitted medical bill found the requestor did not request separate reimbursement of implants. The DWC finds that the insurance carrier's reduction is not supported. The disputed charge are therefore reviewed per applicable fee guideline.

3. DWC Rule 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 and Ambulatory Payment Category (APC).

   DWC Rule 28 TAC 134.403 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantable.

   DWC Rule 28 TAC 134.403 (f) states in pertinent part 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 Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

   The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - Procedure code 25609 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114.

     The OPPS Addendum A rate is $6,397.05 multiplied by 60% for an unadjusted labor amount of $3,838.23, in turn multiplied by facility wage index 0.9873 for an adjusted labor amount of $3,789.48.

     The non-labor portion is 40% of the APC rate, or $2,558.82.

     The sum of the labor and non-labor portions is $6,348.30.

     The Medicare facility specific amount is $6,348.30 multiplied by 200% for a MAR of $12,696.60.

4. The total recommended reimbursement for revenue code 360 is $12,696.60. The insurance carrier paid $6,283.35. The requestor is seeking additional reimbursement of $5,333.50. 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 of $ 5,333.50 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 Carolina Casualty must remit to Houston Methodist Hospital $5,333.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 9, 2023
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.