



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Hermann
Specialty Hospital

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-24-0242-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

October 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 10, 2022	20900	\$1,593.81	\$1,593.81
	Total	\$1,593.81	\$1,593.81

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated September 20, 2023 that is addressed to the Texas Department of Insurance that states "According to TX workers compensation fee schedule the expected reimbursement for CPT code 20900 is \$12,696.61. Please note that separate reimbursement was not requested in Box 80 of UB-04 form for implants, and surgical code should be reimbursed at 200% GARR."

Amount in Dispute: \$1,593.81

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North America is Downs Stanford. The representative was notified of this medical fee dispute on October 10, 2023.

Per 28 Texas Administrative Code §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.

Response submitted by N/A

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 fee guidelines for outpatient hospital services.

Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with 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.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- B13 – Re-evaluated; No additional payment is recommended.

Issues

1. What rule is applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services.

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 implantables.

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 20900 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the highest ranked "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 0.9925 for an adjusted labor amount of \$3,809.44.

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

The sum of the labor and non-labor portions is \$6,368.26.

The Medicare facility specific amount is \$6,368.26 multiplied by 200% for a MAR of \$12,736.52.

3. The total recommended reimbursement for the disputed services is \$12,736.52. The insurance carrier paid \$11,102.80. The requestor is seeking additional reimbursement of \$1,593.81. 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 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 Indemnity Insurance Co of North America must remit to Memorial Hermann Specialty Hospital \$1,593.81 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

December 18, 2023

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.