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

General Information

Requestor Name
Providence Sierra

Respondent Name
Starr Specialty Insurance Co

MFDR Tracking Number
M4-24-0342-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 30, 2022	0250	$1,603.00	$0.00
November 30, 2022	0300	$1,222.00	$0.00
November 30, 2022	0360	$30,756.00	$9,249.54
November 30, 2022	0370	$7,556.00	$0.00
November 30, 2022	0636	$2,511.00	$0.00
November 30, 2022	0710	$5,326.00	$0.00
November 30, 2022	WC Adjustment	-$39,206.04	$0.00
	Total	$9,767.96	$9,249.54

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Gallagher Bassett, but the bill was denied. However, despite the Hospital's efforts and Request for Reconsideration, Gallagher Bassett has not rendered payment."

Amount in Dispute: $9,767.95

Respondent's Position

"…Our bill audit company has determined no further payment is due. The rationale for this determination is found below. …Medical documentation provided does not support the service (or level of service) billed. Description of the unlisted code was not documented."

Response submitted by Gallagher Bassett

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.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract
- 90054 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking payment for outpatient hospital services rendered on November 30, 2022. The insurance carrier denied the disputed services as lacking information or has having billing submission errors. In their response to MFDR the requestor states, "Description of the unlisted code was not documented."

   The surgical code submitted on the medical bill was Code 49329 – "Unlisted laparoscopy procedure abdomen, peritoneum and omentum."

   Review of the submitted operative report found, "Diagnostic laparoscopy, lysis of adhesions taking approximately 50% of the operative time."

   Based on this review, the insurance carrier's denial and position statement are not supported. The services in dispute will be reviewed per applicable fee guidelines.

2. 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 found the following surgical procedure is the only payable code. The fee calculation is shown below.

   - Procedure code 49329 has status indicator J1.

     This code is assigned APC 5361.

     The OPPS Addendum A rate is $5,167.69 multiplied by 60% for an unadjusted labor amount of $3,100.61, in turn multiplied by facility wage index 0.8249 for an adjusted labor amount of $2,557.69.

The non-labor portion is 40% of the APC rate, or $2,067.08.

The sum of the labor and non-labor portions is $4,624.77.

The Medicare facility specific amount is $4,624.77 by 200% for a MAR of $9,249.54.

3. The total recommended reimbursement for the disputed services is $9,249.54. The insurance carrier paid $0.00. The amount due is $9,249.54. 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 Starr Specialty Insurance Co must remit to Providence Sierra $9,249.54 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 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.