TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
North Central Baptist Medical Center

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-24-0889-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
December 21, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 13, 2023	0250	$670.00	$0.00
	0278	$12178.00	$0.00
	0360	$42842.00	$0.00
	0370	$7672.00	$0.00
	0636	$354.00	$0.00
	0710	$23536.00	$0.00
PAYMENTS	PAYMENTS	-6025.13	$0.00
WC ADJUSTMENTS	WC ADJUSTMENTS	-70761.10	$0.00
	Total	$10465.77	$0.00

Requestor's Position

"The Hospital provided the medically necessary services on the above dates of service. The Hospital billed SERVICE LLOYD, but the bill was underpaid. However, despite the Hospital's efforts and Request for Reconsideration SERVICE LLOYD has not rendered proper payment."

Supplemental response dated February 21, 2024

"My client believes this to be an underpayment, and is still expecting $6,714.62.

Amount in Dispute: $10,465.77

Respondent's Position

"The check was sent ahead of schedule which should have reached your facility by now. Enclosed is a copy of the check for $3,747.55 approved by Mitchell International."

Response submitted by: Service Lloyds

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 §133.203 sets out the requirements of requesting implant reimbursement for outpatient hospital claims.
3. 28 TAC §133.210 sets out the requirements of required medical documentation.
4. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

- 155 – Claim specific negotiated discount.
- 16 – Claim service lacks information or has submission/billing error(s).
- 241 – Not documented.
- 188 – Payment of interest/penalty to provider.
- 225 - Penalty or interest payment by payer.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 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.
- 375 – Please see special *NOTE* below.

- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 95 – Plan procedures not followed.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on Workers' compensation jurisdictional regulations or payment policies.
- P63 – Any reduction is in accordance with your Aetna contract.
- PK2 – Subject to Coventry Workers Comp network. A certified HCN.
- U05 – The billed service exceeds the UR amount authorized.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

  This is response to your appeal on the attached claim. After reviewing the service dates in question, we find additional allowance is recommended. Pharmacy charges corrected, Pharmacy charges and UR corrected. Network – Caramor Texas HCN.

Issues

1. Is the injured worker enrolled in a Certified Workers Compensation Network?
2. Did the health care provider seek separate reimbursement of the implants utilized during outpatient surgery?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of surgical procedure rendered January 13, 2023 in an outpatient hospital setting. The insurance carrier's explanation of benefits references several networks and a contract in support of their reduction of payment. Review of the information known to the Division found insufficient evidence to support the injured worker is enrolled in a Certified Healthcare Network. These reductions will not be considered in this review.
2. DWC Rule 28 TAC §133.30 (2)(QQ) states, "UB-04/field 80 is required when separate reimbursement for surgically implanted devices is requested. Review of the submitted medical bill with creation date 01/24/2023 found this field did not contain a request for reimbursement of implants. The disputed medical bill will be reviewed per applicable fee guidelines without separate reimbursement of implants.

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 implantables.

   DWC Rule 28 TAC §134.403 (f)(1)(A)(B) states in pertinent parts 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 sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 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 130 percent.

   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 C1781 represents implants. No separate reimbursement of implants was requested, reimbursement is included with payment for the primary services.

   - Procedure code 49650 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5361. The OPPS Addendum A rate is $5,212.15 multiplied by 60% for an unadjusted labor amount of $3,127.29, in turn multiplied by facility wage index 0.8631 for an adjusted labor amount of $2,699.16.

     The non-labor portion is 40% of the APC rate, or $2,084.86.

     The sum of the labor and non-labor portions is $4,784.02.

     The provider billed 49650 with modifier 50 to report bilateral procedures that are performed on both sides of the body at the same operative session.

     DWC Rule 28 TAC §133.210(a)(b)(c)(2) states,

(a) Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.

(b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.

(c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:

(2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report;

Review of the submitted documentation included with MFDR request did not contain the required operative report. Use of the "50" modifier is not supported.

The Medicare facility specific amount is $4,784.02 multiplied by 200% for a MAR of $9,568.04.

- Procedure code J0330 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J1100 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J1170 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J2704 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J3010 has status indicator N, reimbursement is included with payment for the primary services.

4. The total recommended reimbursement for the disputed services is $9,568.04. The insurance carrier paid $9,772.68. No additional payment 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		February 26, 2024
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.