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 Houston Surgical Hospital

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-24-2224-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
June 10, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 28, 2023	26037	$45,665.28	$0.00
	Total	$45,665.28	$0.00

Requestor's Position

"The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code."

Amount in Dispute: $45,665.28

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response submitted by: Gallagher Bassett

Supplemental response submitted by Gallagher Basset July 23, 2024

"As the charges were not authorized, the Branch will need to provide the response to the State as the denial states – This service was not pre-authorized in conformance with TWCC Rule 134.600."

Supplemental response submitted by Gallagher Basset July 25, 2024

"Attached is a copy of all bills received to date, as well as the corresponding Explanation of Benefits and payment details."

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 billing and reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600.
- P12/90223– Workers' compensation jurisdictional fee schedule adjustment.
- 00663 – Reimbursement has been calculated based on the state guidelines.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.

Issues

1. Did the insurance carrier maintain their denial?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of outpatient hospital surgery services rendered in December of 2023. The insurance carrier denied the charges on the explanation of benefits as lack pre-authorization. Review of the submitted documentation found a payment was made in the amount of $5,926.54 vis draft # 339568437 on August 13, 2024. DWC finds the insurance carrier did not maintain their original denial. The disputed date of service will be reviewed per applicable fee guideline.
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)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits that complies with Labor Code §413.011, 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 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. Review of the submitted medical bill found a request for implants was made. The Medicare facility specific reimbursement amount will 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 26037 has status indicator J1. This code is assigned APC 5113. The OPPS Addendum A rate is $2,976.66 multiplied by 60% for an unadjusted labor amount of $1,786.00, in turn multiplied by facility wage index 0.9817 for an adjusted labor amount of $1,753.32.

  The non-labor portion is 40% of the APC rate, or $1,190.66.

  The sum of the labor and non-labor portions is $2,943.98.

  The Medicare facility specific amount is $2,943.98 multiplied by 200% for a MAR of $5,887.96.

3. The total recommended reimbursement for the disputed services is $5,887.96. The insurance carrier paid $5,926.54. No additional reimbursement 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

Signature	Medical Fee Dispute Resolution Officer	October 11, 2024 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.