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

General Information

Requestor Name
Providence Sierra

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-24-1401-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 27, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 4, 2023	C1781	$3,118.51	$0.00
October 4, 2023	250	$0.00	$0.00
October 4, 2023	80053	$0.00	$0.00
October 4, 2023	85025	$0.00	$0.00
October 4, 2023	85610	$0.00	$0.00
October 4, 2023	85730	$0.00	$0.00
October 4, 2023	88304	$0.00	$0.00
October 4, 2023	71046	$0.00	$0.00
October 4, 2023	49505-50	$0.00	$0.00
October 4, 2023	370	$0.00	$0.00
October 4, 2023	J0171	$0.00	$0.00
October 4, 2023	J0665	$0.00	$0.00
October 4, 2023	J0694	$0.00	$0.00
October 4, 2023	J1170	$0.00	$0.00
October 4, 2023	J2371	$0.00	$0.00
October 4, 2023	J2405	$0.00	$0.00
October 4, 2023	J2704	$0.00	$0.00
October 4, 2023	J3010	$0.00	$0.00
October 4, 2023	J7120	$0.00	$0.00
October 4, 2023	710	$0.00	$0.00

October 4, 2023	93005-XU	$0.00	$0.00
	Total	$3,118.51	$0.00

Requestor's Position

Excerpt from Appeal request: "Per the terms of our agreement governing TEXAS MUTUAL effective 03/01/2008, our expected contract allowable is based on: Pass-throughs ('Drug' or 'Implant' 'MRI'.) Based on this/these service(s), the expected reimbursement amount is $9,620.50. We have received payment in the amount of $6,501.99 with $00.00 as patient responsibility. We are requesting an additional $3,118.51."

Amount in Dispute: $3,118.51

Respondent's Position

"Reimbursement for outpatient hospital services were made in accordance with rule 134.403(f)(1)(A) at 200% as there was no request for reimbursement of implants on the UB04 form submitted in accordance with rule 134.403(f)(1)(B). The original bill and appeal bill are attached and there is no request for implants."

Response submitted by: Texas Mutual Insurance Co.

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.
3. 28 TAC §133.10 sets out required billing forms/formats for health care provider billing procedures.

Denial Reasons

The insurance carrier denied payment for the disputed service with the following claim adjustment codes:

- 305 – THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
- 97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.

- 767 - PAID PER 0/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.

Issues

1. Does a contract or negotiated rate apply to the services in dispute?
2. Is the insurance carrier's denial reason supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. In its appeal request, the requestor refers to a contract agreement between the requesting hospital, Providence Sierra, and the insurance carrier, Texas Mutual. A review of the submitted documentation finds no evidence that a contract agreement or a negotiated rate exists that applies to the services in this dispute.

   DWC finds that a contract or negotiated rate does not apply to the services in this dispute.

2. The requestor is seeking additional reimbursement in the amount of $3,118.51 for a surgical implant product provided in an outpatient hospital setting on October 4, 2023.

   The insurance carrier denied separate reimbursement for the implantable with denial reasons defined above, including that there was no request for separate implant reimbursement in accordance with 28 TAC §134.403.

   28 TAC §134.403, which sets out fee guidelines for outpatient hospital services, states in pertinent part, "(f) 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 following minimal modifications shall be applied.

   (1) 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 <u>provider requests separate reimbursement in accordance with subsection (g) of this section,</u> in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

   (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

   (g) Implantables, <u>when billed separately</u> by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

28 TAC §133.10, which sets out required medical billing forms/formats, states in pertinent part, "(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form…

(2) The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care: …

(QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."

A review of the submitted medical bills finds no evidence that the health care provider requested separate reimbursement for implants on the disputed date of service in accordance with 28 TAC §134.403 and 28 TAC §133.10. Therefore, DWC finds that the insurance carrier's denial reason for the disputed service is supported.

2. The requestor is seeking additional reimbursement in the amount of $3,118.51 for a surgical implant product provided in an outpatient hospital setting on October 4, 2023.

   As demonstrated in finding number one, the insurance carrier's denial reason is supported, therefore, DWC finds that the requestor is not entitled to additional reimbursement for the disputed date of service.

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 that the requestor 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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 27, 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, 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.