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
Crescent Medical Center

Respondent Name
OBI National Insurance Co

MFDR Tracking Number
M4-24-2018-01

Carrier's Austin Representative
Box Number 29

DWC Date Received
May 20, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 26 – 27, 2024	DRG 496	16843.51	$17,046.98
February 13, 2024	PRE-OP	203.47	Inclusive
	Total	$17,046.98	$17,046.98

Requestor's Position

"We are requesting the MAR value of 203.47 for date of service 2/13/24 AND the MAR value of $16,843.51 for date of service 2/26/24-2/27/2024."

Supplemental response July 15, 2024

"Please provide the status of the MFDR."

Supplemental response July 15, 2024

"There was no agreement. We would still like this to be processed."

Amount in Dispute: $17,046.98

Respondent's Position

"Carrier intends to file a response to Crescent Medical Center's DWC-60 filing. Carrier has left voicemail message with Ms. Santos (today) to discuss their request(s) for preauthorization and denial timeline, in order for the carrier to consider the possibility of reaching an agreement on this dispute. Carrier would like to have until the end of today to discuss the matter with Ms. Santon, Dr. Fulp or a Crescent Medical Center representative. If no resolution, Carrier would then file it's response by close of business tomorrow, June 18, 2024."

Response Submitted by: Dean G. Pappas Law Firm

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 §19.2005 sets out the general standards of utilization review.

3. 28 TAC §134.404 sets out the acute care hospital fee guideline for inpatient services.

Denial Reasons

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

- 216 – Based on the findings of a review organization.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 39 – Services denied at the time authorization/pre-certification was requested.
- 18 – Exact duplicate claim/service.

Issues

1. What denials were presented on the explanation of benefits?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. The requestor seeks reimbursement for inpatient hospital surgery rendered in February of 2024. The insurance carrier denied the services in dispute with denial reason codes 216 (description provided above.) The DWC finds that the insurance carrier did not present supporting documentation to the DWC, as required by 28 TAC §133.307 (d)(2)(I). Specifically,

the insurance carrier did not support that it conducted a utilization review and presented an adverse determination to the Requestor as required by 28 TAC §19.2005. The DWC concludes that the issue of "review organization findings" is not supported and the services in dispute are eligible for review.

Additionally, the insurance carrier denied the disputed service as being denied at time of request for prior authorization. Review of the submitted documentation found a recommendation to "Certify" the request for medical services for the injured worker. The certification was dated December 12, 2023 prior to the disputed surgery. The insurance carrier's denial is not supported. The disputed services will be reviewed per applicable fee guideline.

2. The payment of inpatient hospital services is subject to DWC Rule 28 TAC §134.404(f), that requires the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   The division calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is freely available from www.cms.gov.

   Separate reimbursement for implants was not requested. DWC Rule 28 TAC §134.404(f)(1)(A) requires that the Medicare facility specific amount be multiplied by 143%.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 496. The service location is Lancaster, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is 16,141.42. This amount multiplied by 143% results in a MAR of $23,082.23.

3. The requestor is seeking reimbursement in the amount of $17,046.98. 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 OBI National Insurance Co must remit to Crescent Medical Center $17,046.98 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 18, 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.