



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Providence Memorial Hospital

Respondent Name

Sompo America Fire & Marine Insurance Co.

MFDR Tracking Number

M4-25-0316-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 7, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 6, 2023	C1713	\$3,337.89	\$0.00
December 6, 2023	29827-RT	\$0.00	\$0.00
December 6, 2023	Packaged outpatient hospital services	\$0.00	\$0.00
Total		\$3,337.89	\$0.00

Requestor's Position

Excerpt from Reconsideration Request: "Per the terms of our agreement governing GALLAGHER BASSETT W/C 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 \$15,480.49."

Amount in Dispute: \$3,337.89

Respondent's Position

"The carrier's position is that it has paid the provider in the amount that is consistent with and pursuant to the Medical Fee Guidelines... Based on the reimbursement formula and factors applying to the reimbursement, it is the carrier's position that the provider was entitled to the payment of \$12,142.60, which is the amount that the provider is already been paid. The provider is not entitled to any additional payment."

Response submitted by: Flahive, Ogden & Latson

Supplemental Response dated November 7, 2024: "Our Fee Schedule team has confirmed that the bill was priced correctly: When reviewing the bill image, there are no comments in the FL 80 for remarks asking separate payment for implants... If the facility requests separate payment for implants, the facility should have provided written certification requesting separate reimbursement for implants."

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 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:

- 97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE CODE IS INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DOES NOT WARRANT A SEPARATE PAYMENT.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- B13,90202 - PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
- 247 - A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.

Issues

1. Does a contract or negotiated rate apply to the services in dispute?
2. Did the requestor, Providence Memorial Hospital, request separate reimbursement for the disputed surgical implantable items in accordance with DWC Rules?
3. Is the requester entitled to additional reimbursement?

Findings

1. In its reconsideration request, the requestor refers to a contract agreement between the requesting hospital, Providence Memorial Hospital, and the insurance carrier, Sompo America Fire & Marine Insurance Company. 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 \$3,337.89 for surgical implant products provided in an outpatient hospital setting on December 6, 2023.

The insurance carrier denied payment for the implantable items with denial reasons defined above, indicating that payment for the disputed service was included in the payment of another procedure/service provided on the same date.

Additionally, the insurance carrier's supplemental response asserts 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 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.

(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, when billed separately 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-ons 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. Therefore, DWC finds that Providence Memorial Hospital did not request separate payment for surgical implantable items in accordance with DWC Rules 28 TAC §134.403 and 28 TAC §133.10.

3. The requestor is seeking additional reimbursement in the amount of \$3,337.89 for surgical implantable products provided in an outpatient hospital setting on December 6, 2023.

Because the health care provider did not request separate reimbursement in accordance with 28 TAC §134.403 and 28 TAC §133.10, for the disputed implantable items, 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

November 13, 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 electrónico CompConnection@tdi.texas.gov.