TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
North Central Surgical Hospital

**Respondent Name**
Continental Insurance Co

**MFDR Tracking Number**
M4-21-0824-01

**Carrier's Austin Representative**
Box Number 57

**MFDR Date Received**
January 21, 2021

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per EOB, the appeal was denied as a duplicate. The original EOB was denied stating lacking preauthorization. Please note that services were authorized under Precert #:

**Amount in Dispute:** $18,933.20

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Prior to the receipt of this Medical Fee Dispute, the Carrier paid CPT 29880 Mar values in the total recommended allowance amount of $11,716.24 (remaining CPT Codes bundled)."

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| April 29, 2020 | Outpatient Hospital Services | $18,933.20 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
    - 18 – Exact duplicate claim/service
    - 197 – Payment denied/reduced for absence of precertification/authorization

**Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking reimbursement in the amount $18,933.20 for outpatient hospital services rendered on April 29, 2020. The insurance carrier denied the disputed services based on lack of preauthorization.

   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).

   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 143 percent when a separate request for implant reimbursement is not made or a facility or surgical implant provider requests separate reimbursement the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. The requestor indicates separate reimbursement of the implants is being sought.

   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 C1713 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
   - Procedure code C1762 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
   - Procedure code 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 80053 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 29880 has a status indicator of J1. Medicare ranks J1 procedures and only the highest ranking code receives reimbursement. The ranking of code 29880 is 1798. The ranking of code 29888 is 304. Only code 29888 will receive reimbursement.
   - Procedure code 29888 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is $5,981.95. This is multiplied by 60% for an unadjusted labor amount of

$3,589.17, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $3,465.34. The non-labor portion is 40% of the APC rate, or $2,392.78. The sum of the labor and non-labor portions is $5,858.12. The Medicare facility specific amount is $5,858.12. This is multiplied by 130% for a MAR of $7,615.56.

- Per Medicare policy, procedure code 97110 is bundled into code 29888.
- Per Medicare policy, procedure code 97116 is bundled into code 29888.
- Procedure code J0131 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 J1885 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2001 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2250 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2405 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.
- The total net invoice amount of the itemized bill is $2,899.53.
  - "sheath tibl" as labeled on the invoice with a cost per unit of $358.00;
  - "screw bone 8mm" as labeled on the invoice with a cost per unit of $347.00;
  - "acl interference screw 7" as labeled on the invoice with a cost per unit of $91.33;
  - "spiked washer 20mm" as labeled on the invoice with a cost per unit of $136.88;
  - "screw bone 4.5mm x 40mm" as labeled on the invoice with a cost per unit of $66.32;
  - "allograft achilles tendon" as labeled on the invoice with a cost per unit of $1,900.00.

  The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $289.95. The total recommended reimbursement amount for the implantable items is $3,189.48.

2. The total recommended reimbursement for the disputed services is $10,805.04. The insurance carrier paid $11,716.24. Additional payment is not recommended.

**Conclusion**

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

| Signature | Medical Fee Dispute Resolution Officer | February 12, 2021<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.