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
Crescent Medical Center

Respondent Name
Everest National Insurance Co

MFDR Tracking Number
M4-21-1254-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 24, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The implants were not paid. We are expecting an additional $11,352.8i0 for implants, REV 278."

Amount in Dispute: $11,352.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the carrier is reprocessing the provider's bill. We would ask that the carrier be given that opportunity and if the provider is in agreement, then once the provider has received payment, we would sk that the provider withdraw its request for Medical Fee Dispute Resolution on the basis that the medical fee dispute will have resolved."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 30, 2020	Outpatient Hospital Services	$11,352.80	$11,352.80

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:
    - 5484 – Please resubmit with detailed implant log along with invoices. This information is necessary for accurate repricing of the implantable device charges.

- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 877 – Reimbursement is based on the contracted rate
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carriers' reduction based on a contract supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount $11,352.80 for outpatient hospital services rendered in October 2020. The insurance carrier reduced the disputed services based on contracted rate.

   Review of the submitted documentation found insufficient evidence to support the claimant was enrolled in a Certified Network on the date of service. The insurance carriers' reduction is not supported. The services in dispute will be reviewed per applicable fee guideline.

2. Division 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).

   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 is multiplied by 143 percent when a separate request for implant reimbursement is not made and 130 percent when separate reimbursement for implants is made.

   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 86900 has status indicator Q1, reimbursement is packaged into the J1 procedure 27446.
   - Procedure code 86850 has status indicator Q1, reimbursement is packaged into the J1 procedure 27446.
   - Procedure code 27446 has status indicator J1. All covered services on the bill are packaged with the primary "J1" procedure.

     This code is assigned APC 5115. The OPPS Addendum A rate is $11,900.71.

     This is multiplied by 60% for an unadjusted labor amount of $7,140.43, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $6,894.09.

     The non-labor portion is 40% of the APC rate, or $4,760.28.

The sum of the labor and non-labor portions is $11,654.37.

The Medicare facility specific amount is $11,654.37.

This is multiplied by 130% for a MAR of $15,150.68.

- Code 27437 has status indicator J1. Per Medicare policy J1 procedures are ranked (ranking found at www.cms.hhs.gov. appendix J) and only the highest ranking J1 procedure is payable. In this case Code 27446 has a ranking of 110. Code 27437 has a ranking of 318. Code 27437 is packaged into the higher-ranking code 27446.
- Procedure code J0690 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 J2405 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.

Separate reimbursement of the implants was requested. The medical bill contained charges for following items:

- "Cement Cobalt" as identified in the itemized statement however, the submitted invoice did not list a cost and extended price for this item. Separate reimbursement is not recommended.
- "Tibial Plateau 11.25mm Titanim" as identified in the itemized statement and labeled on the invoice as "Endo Sled Tibial Comp" with a cost per unit of $3,983.00.
- "Femoral 18.52mm Component Medium" as identified in the itemized statement and labeled on the invoice as "Endo Sled Knee Fem Comp" with a cost per unit of $5,844.00.

The total net invoice amount is $9,827.00.

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 $982.70.

The total recommended reimbursement amount for the implantable items is $10,809.70.

3. The total recommended reimbursement for the disputed services is $25,960.38. The insurance carrier paid $3,906.95. The requestor is seeking additional reimbursement of $11,352.80. This amount is 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 established payment is due. As a result, the amount ordered is $11,352.80.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $11,352.80, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

[redacted]	[redacted]	June 24, 2021
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 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.