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

General Information

Requestor Name
USMD Hospital at Arlington

Respondent Name
Associated Indemnity Corp

MFDR Tracking Number
M4-21-1959-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 25, 2021	Outpatient Surgery, Implants	$11,740.52	$2,303.27
	Total	$11,740.52	$2,303.27

Requestor's Position

The requestor did not submit a position statement but submit a copy of their reconsideration that states, "...the invoice and the letter of certification were attached to the original bill."

Amount in Dispute: $11,740.52

Respondent's Position

On July 15, 2021, the carrier issued an additional check to the provider in the amount of $14,21.00. Accordingly, there is now been an overpayment of $2,280.48.

Response Submitted by: Flahive, Ogden & Latson

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 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.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 252 – An attachment/other documentation is required to adjudicate this claim/service
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carriers' position statement supported?

2. What rule applies for determining reimbursement for the disputed services?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of $11,740.52 for a surgical procedure and implants performed in February 2021. The insurance carrier denied the implants based on lack of documentation but upon reconsideration an additional payment was made.

   The respondent states in their position statement that an overpayment exists. Review of the applicable fee guidelines does not support their position. The fee calculation is discussed below.

2. DWC 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).

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 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. When separate payment for implants is requested the Medicare facility specific amount is multiplied by 130 percent.

Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code 62362 has status indicator J1. This code is assigned APC 5471. The OPPS Addendum A rate is $17,031.90. This is multiplied by 60% for an unadjusted labor amount of $10,219.14, in turn multiplied by facility wage index 0.9707 for an adjusted labor amount of $9,919.72.

  The non-labor portion is 40% of the APC rate, or $6,812.76.

  The sum of the labor and non-labor portions is $16,732.48.

  The Medicare facility specific amount is $16,732.48 multiplied by 130% for a MAR of $21,752.22.

- Review of the submitted itemized statement found the following implants:

  - Catheter Ascenda with a cost per unit of $1,100.00.
  - Synchromed II infusion pump with a cost per unit of $11,800.00.

  The total net invoice amount is $12,900.00. 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 $1,110.00.

  The total recommended reimbursement amount for the implantable items is $14,010.00.

3. The total recommended reimbursement for the disputed services is $35,762.22. The insurance carrier paid $33,458.95. The amount due is $2,303.27. 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 of $2,303.27 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 Associated Indemnity Corp must remit to USMD Hospital at Arlington $2,303.27 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fe [redacted] e [redacted] ion Officer	October 4, 2021 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.