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

General Information

Requestor Name
BAPTIST HEALTH SYSTEM

Respondent Name
AMERICAN ZURICH INSURANE COMPANY

MFDR Tracking Number
M4-22-0458-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 27, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 4, 2021	Outpatient Facility Charges C1713	$5,760.02	$0.00
	Total	$5,760.02	$0.00

Requestor's Position

"Revenue Code 278 charges are reimbursed as charges in service type $21,190. 00 exceeds threshold of $3,000 then cost+ less of 10 percent of $1,000 per item not to exceed $2,000.00 per admission with reimbursement of $7,953.19. OP Surg Implants greater than $3,000 are payable at 130% of Standard Medicare OPPS pricing in the amount of $14,770.21. Mission Trail Baptist is requesting BROADSPIRE review implantable TDI-DWC rules; updated claim and reprocess and issue the additional $5,855.02 due on Outpatient Implantable."

Amount in Dispute: $5,760.02

Respondent's Position

"No additional fees have been recommended as per the attached EOB. The hospital outpatient allowance was calculated according to the APC rate, plus a markup. The value of this procedure is packaged into the payment of other services performed on the same date of service."

Response Submitted by: Broadspire A Crawford Company

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 Hospital Facility Services.

Denial Reasons

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

- P13 – Payment reduced or denied based on workers compensation jurisdictional regulations or payment policies.
- 885 – Review of this code has resulted in an adjusted reimbursement.
- W3 – IN accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- A19 – Upon further review, additional payment is warranted.

Issues

1. Is the insurance carriers' denial supported?
2. What rule applies for determining reimbursement for the disputed services?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for the implantable billed under HCPCS Code C1713 and rendered on March 4, 2021. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply the 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 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.

The total net invoice amount (exclusive of rebates and discounts) is $2,200.00. 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-ons per admission is $220.00. The total recommended reimbursement amount for the implantable items is $2,420.00.

The total recommended reimbursement for the disputed services is $16,911.52. The insurance carrier paid $16,963.38. Additional payment is not 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 8, 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.