TDI Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
St Joseph Medical Center

Respondent Name
Graphic Arts Mutual Insurance Co

MFDR Tracking Number
M4-22-1078-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
February 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 17, 2021	Outpaient Hospital Services	$3,993.09	$3,992.84
	Total	$3,993.09	$3,992.84

Requestor's Position

This bill remains underpaid after appeal.

Amount in Dispute: $3,993.09

Respondent's Position

The charges in questions for St. Joseph Medical were reviewed under bill number K6TX-81321, which allowed $4,860.04 and was paid July 28, 2021 with Utica check #1683030 and bill number K6TX-82531, a re-evaluation which allowed an additional $2,555.52 and was paid October 27, 2021 with Utica check #1740295. The implants were carved out and set to Foresight fo re-pricing and thereby not included in the recommendation made under the other bill reviews.

Response submitted by: Utica National Insurance Group

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 [description].

Denial Reasons

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

- 197 – Precertification/authorization/notification absent
- 252 – An attachment/other documentation is required to adjudicate the claim/service
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Is the insurance carrier's reduction supported?

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

3. Is the requester entitled to additional reimbursement?

Findings

1. The insurance carrier indicates the implants were carved out and paid by ForeSight. Review of the submitted medical bill does not support the requestor sought separate payment of the implants when the bill was submitted or that a payment of any amount was made by ForeSight. The insurance carrier's position is not supported.

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).

   DWC 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 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. This amount is multiplied by 200 per cent when separate reimbursement of the implants is not requested by the health care provider.

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

- Procedure code 64890 has status indicator J1 paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure.

  This code is assigned APC 5432. The OPPS Addendum B rate is $5,700.29. This is multiplied by 60% for an unadjusted labor amount of $3,420.17, in turn multiplied by facility wage index 1.0011 for an adjusted labor amount of $3,423.93.

  The non-labor portion is 40% of the APC rate, or $2,280.12.

  The sum of the labor and non-labor portions is $5,704.05.

  The Medicare facility specific amount is $5,704.05 multiplied by 200% for a MAR of $11,408.10.

2. The total recommended reimbursement for the disputed services is $11,408.10. The insurance carrier paid $7,415.26. The amount due is $3,992.84. 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 $3,992.84 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. {It is ordered that Graphic Arts Mutual Insurance Co must remit to St Joseph Hospital $3,992.84 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 28, 2022
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 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.