TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
Jackson Madison County

**Respondent Name**
Guideone Mutual Insurance Co

**MFDR Tracking Number**
M4-22-2211-01

**Carrier's Austin Representative**
Box Number 1

**DWC Date Received**
June 9, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| March 2, 2022 | Rev Codes 258-730 | $38,797.59 | $38,797.59 |
| | Total | $38,797.59 | $38,797.59 |

## Requestor's Position

No position statement was submitted by the requestor.

**Amount in Dispute:** $38,797.59

## Respondent's Position

"CorVel will maintain the requestor, Jackson Madison County is not entitled to additional reimbursement for date of service 03/22/22 in the amount of $38,797.59 based on DWC adopted medical outpatient hospital fee guidelines, Medicare payment policies and correct coding initiative (CCI) edits in effect at the time services were provided."

**Response submitted by:** CorVel

# 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 the payment for the disputed services with the following claim adjustment codes:

- 234 – This procedure is not paid separately
- 352 – Network disc not applicable to procedure billed
- RN – Not paid under OPPS; services included in APC rate
- P13 – Payment reduced/denied based on state WC regs/policies
- P14 – Payment is included in another svc/procedure occurring on same day
- 350 – Network allowance
- 59 – Distinct procedureal service
- RZ0 – Status Indicator: Q4 packaged lab service
- W3 – Appeal/reconsideration

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of outpatient hospital services rendered in March 2022. The insurance carrier reduced the payment based on state workers' compensation regulations and policies.

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 (e) (1) (2) states in pertinent part regardless of billed amount, reimbursement shall be the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

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

- Procedure code C1820 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 80048 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 85610 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 85730 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 81001 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.

- Procedure code 71046 has status indicator Q3 and is packaged into J1 comprehensive rate.

- Procedure code 63685 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 5465. The OPPS Addendum A rate is $30,063.48 multiplied by 60% for an unadjusted labor amount of $18,038.09, in turn multiplied by facility wage index 0.8296 for an adjusted labor amount of $14,964.40.

  The non-labor portion is 40% of the APC rate, or $12,025.39.

  The sum of the labor and non-labor portions is $26,989.79.

  The Medicare facility specific amount is $26,989.79 multiplied by 200% for a MAR of $53,979.58.

- Procedure code 93005 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for comprehensive J1 procedure.

2. The total recommended reimbursement for the disputed services is $53,979.58. The insurance carrier paid $5,002.41. The requestor is seeking additional reimbursement of $38,797.59. 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 $38,797.59 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 Guideone Mutual Insurance Co must remit to Jackson Madison County $38,797.59 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | July 7, 2022<br>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.