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

General Information

Requestor Name
Providence Memorial Hospital

Respondent Name
East Tx Educational Ins Assn

MFDR Tracking Number
M4-22-2272-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
June 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 23, 2021	636	$2261.00	$0.00
	250	$237.00	$0.00
	637	$50.98	$0.00
	278	$53138.30	$1,892.24
	360	$15495.22	$0.00
	710	$9175.00	$0.00
	370	$4148.00	$0.00
WORK COMP ADJUSTMENTS	WC ADJ	-80290.60	
	Total	$4214.90	$1,892.24

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed CLAIMS ADMINISTRATOR, but the bill was denied. The Hospital requested CLAIMS ADMINISTRATOR review denial and issue payment. However, despite the Hospital's efforts and Request for Reconsideration, and CLAIMS ADMINISTRATOR Explanation of Benefits."

Amount in Dispute: $4214.90

Respondent's Position

"…The two reconsideration document in letter form that separate implants were being requested, but for each of those we requested a copy of the manufacturers invoice. We received a document with each but this was largely illegible. Attached are copies of the bills and EOB's. As we requested the manufacturers invoice twice, but never received a copy that could be read, it is our position that no additional reimbursement would be due."

Response submitted by: CAS – Claims Administrative Services, Inc.

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:

- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 606 – The allowance for this line item is based on an outlier reimbursement
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 350 – Bill has been identified as arequest for reconsideration or appeal

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

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

   - Procedure code C1762 represents the implantable. The requestor used the appeals process to request separate reimbursement.

     DWC Rule 28 TAC §134.403 (g) states in pertinent part, iImplantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

     Review of the submitted documents with the request for MFDR found an invoice with the required cost certification from CTM BioMedical. The product code listed was the same as that on the itemized statement submitted by the requestor. The total cost listed was $4,990.00.

     Based on this review per the above rule the allowable for the implant is calculated as the total net invoice amount (exclusive of rebates and discounts) is $4,990.00. 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 $499.00. The total recommended reimbursement amount for the implantable items is $5,489.00.

   - Procedure code 29822 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 5113. The OPPS Addendum A rate is $2,830.40 multiplied by 60% for an unadjusted labor amount of $1,698.24, in turn multiplied by facility

wage index 0.7904 for an adjusted labor amount of $1,342.29.

The non-labor portion is 40% of the APC rate, or $1,132.16.

The sum of the labor and non-labor portions is $2,474.45.

The Medicare facility specific amount is $2,474.45 multiplied by 130% for a MAR of $3,216.79.

- Procedure code J0171 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J0330 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J0690 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J1100 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J2250 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 J2704 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J2759 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J2795 has status indicator N,; reimbursement is included with payment for the primary services.
- Procedure code J3010 has status indicator N,; reimbursement is included with payment for the primary services.
- Procedure code J7120 has status indicator N, reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is $10,437.00. The insurance carrier paid $8,544.76. The amount due is $1,892.24. 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 $1,892.24 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 East Tx Educational Ins Assn must remit to Providence Memorial Hospital $1,892.24 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 15, 2022 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.