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
Memorial Hermann
Specialty Hospital

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-23-0449-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
October 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 7, 2022	C1713	$1.669.80	$0.00
January 7, 2022	C1776	$7,487.70	$0.00
January 7, 2022	23472	$0.00	$0.00
January 7, 2022	131-272	$0.00	$0.00
	Total	$544.92	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $544.92

Respondent's Position

"The amount of reimbursement awarded for C1713 was $1,669.80 and C1776 was $7,487.70. This amount was based on the manufacturers' invoice, the fee guidelines and all applicable discounts for the procedure performed. The amount reimbursed was correct based on the Fee Guidelines"

Response submitted by: White Espey PLLC

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:

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. What rule applies for determining reimbursement?
2. How is the payment of implants calculated?
3. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking additional payment of implants provided as part of an outpatient hospital surgery rendered in January 2022. The insurance carrier made a reduction based on worker's compensation fee guideline(s).

   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) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract reimbursement shall be 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 found a request for separate reimbursement of implants was made. DWC Rule 134.403 (f) (1) (B) states in pertinent part, when a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

The calculation of the applicable Medicare facility specific amount calculation based on fee guidelines referenced above is shown below.

- Procedure code 23472 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 5115. The OPPS Addendum A rate is $12,593.29.

  This is multiplied by 60% for an unadjusted labor amount of $7,555.97, in turn multiplied by facility wage index 0.9873 for an adjusted labor amount of $7,460.01.

  The non-labor portion is 40% of the APC rate, or $5,037.32.

  The sum of the labor and non-labor portions is $12,497.33.

  The Medicare facility specific amount is $12,497.33. This is multiplied by 130% for a MAR of $16,246.53.
- Procedure code 80053, billed December 31, 2021, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 87081, billed December 31, 2022, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 36415 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 86920 has status indicator Q1, reimbursement is packaged with payment of primary J1 procedure.
- Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 73020 has status indicator Q1, reimbursement is packaged with payment of primary J1 procedure.
- Procedure code J0690 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J0690 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J1100 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J2001 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J2405 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J3010 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J0690, billed January 8, 2022, has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code G0378 has a status indicator of J2. The applicable Medicare payment policy is found at www.cms.gov, Chapter 4, Section 10.2.3 - Comprehensive APCs States in pertinent part, "*The single payment for a comprehensive claim is based on the rate associated with either the J1 service or the specific combination of J2 services. When a J1 service and a J2 service are reported on the same claim, the single payment is based on the rate associated with the J1 service,*" No separate payment is recommended.

2. The total net invoice amount (exclusive of rebates and discounts) is $8,866.00. 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 $886.60. The total recommended reimbursement amount for the implantable items is $9,752.60.
3. The total recommended reimbursement for the disputed services is $25,999.13. The insurance carrier paid $33,319.66. 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 16, 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.