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
Methodist Charlton Medical Center

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-23-0903-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 9, 2022	250	$28.00	$0.00
May 9, 2022	250	$3.75	$0.00
May 9, 2022	250	$1.25	$0.00
May 9, 2022	Q9967	$340.75	$0.00
May 9, 2022	80053	$656.00	$0.00
May 9, 2022	85025	$498.29	$0.00
May 9, 2022	80048	$556.42	$0.00
May 9, 2022	80061	$399.00	$0.00
May 9, 2022	82962	$97.90	$0.00
May 9, 2022	82962 91	$170.00	$0.00
May 9, 2022	83036	$127.00	$0.00
May 9, 2022	83090	$732.00	$0.00
May 9, 2022	83721 91	$387.00	$0.00
May 9, 2022	84484	$720.00	$0.00
May 9, 2022	84484 91	$360.00	$0.00
May 9, 2022	84703	$45.00	$0.00
May 9, 2022	85610	$190.00	$0.00
May 9, 2022	85730	$190.00	$0.00
May 9, 2022	71045 TC	$326.22	$0.00

May 9, 2022	70450 TC	$4,578.00	$0.00
May 9, 2022	70496 TC	$4,348.05	$0.00
May 9, 2022	70498 TC	$4,341.21	$0.00
May 9, 2022	97110 GP	$121.83	$0.00
May 9, 2022	97536 GO	$300.53	$0.00
May 9, 2022	97166 GO	$125.93	$0.00
May 9, 2022	92523 GN	$277.60	$0.00
May 9, 2022	92610 GN	$525.00	$0.00
May 9, 2022	99285 25	$1,712.13	$6.33
May 9, 2022	93306 TC	$2,841.27	$0.00
May 9, 2022	J0360	$396.00	$0.00
May 9, 2022	J0780	$152.50	$0.00
May 9, 2022	J1200	$8.00	$0.00
May 9, 2022	J1650	$417.00	$0.00
May 9, 2022	93005	$512.00	$0.00
	G0378	$3,414.00	$0.00
	Total	$32,846.14	$6.33

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $32,846.14

Respondent's Position

"The carriers EOBs note that the services for which the provider was not paid were because that service was included in the payment for another service. To pay both services would amount to double payment."

Response submitted by: Flahive, Ogden & Latson

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:

- 236 – This procedure or procedure/modifier combination is not compatible with another pservice/procedure that has already been adjudicated
- 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
- W3 – In accordance with TDI-DWC Rule 134.804, This bill has been identified as a request 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. The requetor is seeking additional payment for outpatient hospital services rendered in May of 2022. The insurance carrier reduced the payment based on packaging and workers' compensation fee schedule. The maximum allowable reimbursement is calculated as follows.

   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 and the applicable fee guidelines referenced above is shown below.

- Procedure code Q9967 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code 80053 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 85025 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.
- Per Medicare comprehensive payment policy, procedure code 80061 is packaged into code 99285 whose APC is 8011.
- Procedure code 82962 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
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- Procedure code 82962 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 83036 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 83090 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.

- Procedure code 83721 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 84484 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 84484 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 84484 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 84703 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 85730 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 71045 has status indicator Q3 and is packaged into comprehensive APC 8011, status indicator J2.
- Procedure code 70450 has status indicator Q3 and is packaged into comprehensive APC 8011, status indicator J2.
- Procedure code 70496 has status indicator Q3 and is packaged into comprehensive APC 8011, status indicator J2.
- Procedure code 70498 has status indicator Q3 and is packaged into comprehensive APC 8011, status indicator J2..
- Procedure code 97110 has status indicator A and is packaged into comprehensive APC 8011, status indicator J2.
- Procedure code 97116 has status indicator A and is packaged into comprehensive APC 8011, status indicator J2.
- Procedure code 97116 has status indicator A and is packaged into comprehensive APC 8011, status indicator J2.
- Procedure code 97162 has status indicator A and is packaged into comprehensive APC 8011, status indicator J2.
- Procedure code 97110 has a status indicator A and is packaged into comprehensive APC 8011, status indicator J2.
- Procedure code 97535 has a status indicator A and is packaged into comprehensive

APC 8011, status indicator J2.

- Procedure code 97166 has a status indicator A and is packaged into comprehensive APC 8011, status indicator J2.

- Procedure code 92523 has status indicator A and is packaged into comprehensive APC 8011, status indicator J2.

- Procedure code 92610 has status indicator A and is packaged into comprehensive APC 8011, status indicator J2.

- Procedure code 99285 has status indicator J2 and is assigned APC 8011. The OPPS Addendum A rate is $2,331.90 multiplied by 60% for an unadjusted labor amount of $1,399.14, in turn multiplied by facility wage index 0.9552 for an adjusted labor amount of $1,336.46.

  The non-labor portion is 40% of the APC rate, or $932.76.

  The sum of the labor and non-labor portions is $2,269.22.

  The Medicare facility specific amount is $2,269.22 multiplied by 200% for a MAR of $4,538.44.

- Procedure code 93306 has a status indicator of S and is packaged into comprehensive APC 8011, status indicator J2.

- Procedure code 70551 has status indicator Q3 and is packaged into comprehensive APC 8011, status indicator J2.

- Procedure code J0360 has status indicator N, reimbursement is included with payment for the primary services.

- Procedure code J0780 has status indicator N, reimbursement is included with payment for the primary services.

- Procedure code J0780 has status indicator N, reimbursement is included with payment for the primary services.

- Procedure code J1200 has status indicator N, reimbursement is included with payment for the primary services.

  Procedure code J1200 has status indicator N, reimbursement is included with payment for the primary services.

- Procedure code J1650 has status indicator N, reimbursement is included with payment for the primary services.

- Procedure code J1650 has status indicator N, reimbursement is included with payment for the primary services.

- Procedure code J1650, has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code 93005 has status indicator Q1, is packaged into comprehensive APC 8011, status indicator J2.
- Procedure code G0378 has status indicator N, reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is $4,538.44. The insurance carrier paid $4,532.11. The amount due is $6.33. 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 $6.33 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 respondent must remit to requestor $6.33 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	January 23, 2023 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.