Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Providence Hospital

Respondent Name
El Paso County

MFDR Tracking Number
M4-23-0948-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
Decembe 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 24, 2022	250	$0.00	$0.00
June 24, 2022	C1762	$0.00	$0.00
June 24, 2022	80053	$0.00	$0.00
June 24, 2022	85027	$0.00	$0.00
June 24, 2022	71046	$0.00	$0.00
June 24, 2022	29881-LT	$3960.71	$0.00
June 24, 2022	370	$0.00	$0.00
June 24, 2022	97161-GP	$0.00	$0.00
June 24, 2022	J0690	$0.00	$0.00
June 24, 2022	J1170	$0.00	$0.00
June 24, 2022	J1885	$0.00	$0.00
June 24, 2022	J2250	$0.00	$0.00
June 24, 2022	J2405	$0.00	$0.00
June 24, 2022	J2704	$0.00	$0.00
June 24, 2022	J2795	$0.00	$0.00
June 24, 2022	J3010	$0.00	$0.00
June 24, 2022	J7120	$0.00	$0.00
	Total	$3960.71	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but submit a copy of their reconsideration request that states, "Based on this/these service(s), the expected reimbursement amount is $9,137.55. We have received payment in the amount of $5,176.84 with $00.00 as patient responsibility. We are requesting an additional $3,960.71."

Amount in Dispute: $3,960.71

Respondent's Position

"The provider's DWC-60 packet includes the carrier's EOR. The carrier's position is consistent with its EOR. The provider was requesting separate reimbursement for the implants but the implants were not reimbursable The provider is not entitled to any reimbursement."

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:

- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 97 – Payment adjusted because the benefit for this service is included in the paym,ent/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. What rule is applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered in June 2022. The insurance carrier reduced the allowable based on workers' compensation guideline.

   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*. Separate reimbursement of the implants was not requested on the submitted medical bill.

   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 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement.
   - Procedure code 80053 has status indicator Q4, and is packaged into the primary comprehensive procedure.
   - Procedure code 85027 has status indicator Q4, and is packaged into the primary comprehensive procedure.
   - Procedure code 71046 has status indicator Q3, and is packaged into the primary comprehensive procedure.
   - Procedure code 29881 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 $2,892.28 multiplied by 60% for an unadjusted labor amount of $1,735.37, in turn multiplied by facility wage index 0.8249 for an adjusted labor amount of $1,431.51.

The non-labor portion is 40% of the APC rate, or $1,156.91.

The sum of the labor and non-labor portions is $2,588.42.

The Medicare facility specific amount is $2,588.42 multiplied by 200% for a MAR of $5,176.84.

- Procedure code 97161 is packaged into the primary comprehensive procedure.
- Procedure code J0690 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J1170 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J1885 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J2250 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 J2704 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J2790 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 J7120 has status indicator N, for packaged codes integral to the total service package with no separate payment.

2. The total recommended reimbursement for the disputed services is $5,176.84. The insurance carrier paid $5,176.84. 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 isnot entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 22, 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.