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

General Information

Requestor Name
Crescent Medical Center

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-23-1023-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 28, 2022	Implants Rev 0278	$2090.00	$3.07
March 28, 2022	REV 360	Unknown	$0.00
March 28, 2022	All Other	$0.00	$0.00
	Total	Unknown	$3.07

Requestor's Position

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

Amount in Dispute: $2090.00

Respondent's Position

The Austin carrier representative for Zurich American Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 10, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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:

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 58 -1 – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service
- P12 -7- Workers' Compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier's denial supported?

2. What rule(s) is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered in March 2022. The insurance carrier denied Code 22830, and 22830 -59 as rendered in an inappropriate or invalid place of service.

   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.

Review of Code 22830 indicates a Status Indicator of "C" which means, Not paid under OPPS. The insurance carrier's denial is supported no additional payment is recommended.

2. As shown above, 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. DWC Rule 28 TAC 134.403 (f)(1)(B) states in pertinent part, the sum of the Medicare facility specific reimbursement amount shall be multiplied by 130 percent when a facility requests separate reimbursement for implants.

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

DWC Rule §134.403(g) Implantables, 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.

The following items were billed under Revenue Code 278.

- "DBM Putty 10cc Reficio" as identified in the itemized statement and labeled on the invoice as "10cc DBM Putty" with a cost per unit of $950.00;
- "Putty 10cc DBM Reficio" as identified in the itemized statement and labeled on the invoice as "10cc DBM Putty" with a cost per unit of $950.00.
- The total net invoice amount (exclusive of rebates and discounts) is $1,900.00. 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 $190.00. The total

recommended reimbursement amount for the implantable items is $2,090.00.

- Procedure code 72100 has status indicator Q1, for STV-packaged codes; This code is assigned APC 5522.

  The OPPS Addendum A rate is $111.19 multiplied by 60% for an unadjusted labor amount of $66.71, in turn multiplied by facility wage index 0.9552 for an adjusted labor amount of $63.72.

  The non-labor portion is 40% of the APC rate, or $44.48.

  The sum of the labor and non-labor portions is $108.20.

  The Medicare facility specific amount is $108.20 is multiplied by 130% for a MAR of $140.66.

3. The total recommended reimbursement for the disputed services is $2,230.66. The insurance carrier paid $2,227.59. The amount due is $3.07. 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 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 Zurich American Insurance Co must remit to Crescent Medical Center $3.07 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 26, 2023
Signature	Medical Fee Dispute Resolution Officer	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.