

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

MHHS Hermann Hospital

**Respondent Name**

Zurich American Insurance Co

**MFDR Tracking Number**

M4-23-1454-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

February 17, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2022	X-RAY	\$1,031.75	\$0.00
September 2, 2022	EMERGENCY ROOM	\$179.00	\$0.00
September 2, 2022	EMERGENCY ROOM	\$1,212.00	\$0.00
September 2, 2022	EMERGENCY ROOM	\$656.00	\$0.00
September 2, 2022	EMERGENCY ROOM	\$991.50	\$0.00
September 2, 2022	EMERGENCY ROOM	\$237.50	\$0.00
September 2, 2022	EMERGENCY ROOM	\$4,626.75	\$1635.34
September 2, 2022	DRUGS	\$290.00	\$0.00
September 2, 2022	DRUGS	\$17.00	\$0.00
September 2, 2022	DRUGS	\$35.00	\$0.00
September 2, 2022	DRUGS	\$3.00	\$0.00
	Total	\$9,279.50	\$1635.34

### Requestor's Position

"This is a bill for services provided by Memorial Hermann Hospital for a workers comp injury for the above named patient. As of right now, the medical bill has not been paid by the carrier and is being denied as a duplicate to the physicians bill incorrect. The carrier has refused to reprocess this bill for payment after a reconsideration was sent."

**Amount in Dispute:** \$9,279.50

## **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 February 28, 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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' Compensation jurisdictional fee schedule adjustment
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or (illegible)

### Issues

1. Did the respondent support denial?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

### Findings

1. Neither party submitted the original explanation of benefits for the services in dispute but the requestor did submit the reconsideration explanation of benefits and state in their position statement that, "...denied as a duplicate to the physicians bill..." Insufficient evidence was found to support the insurance carrier's non-payment. The disputed services will be reviewed per applicable fee guidelines.
2. 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](http://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 73130 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
- Procedure code 90471 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
- Procedure code 96365 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is \$208.93 multiplied by 60% for an unadjusted labor amount of \$125.36, in turn multiplied by facility wage index 0.9873 for an adjusted labor amount of \$123.77.

The non-labor portion is 40% of the APC rate, or \$83.57.

The sum of the labor and non-labor portions is \$207.34.

The Medicare facility specific amount is \$207.34 multiplied by 200% for a MAR of \$414.68.

- Procedure code 96366 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is \$40.87 multiplied by 60% for an unadjusted labor amount of \$24.52, in turn multiplied by facility wage index 0.9873 for an adjusted labor amount of \$24.21.

The non-labor portion is 40% of the APC rate, or \$16.35.

The sum of the labor and non-labor portions is \$40.56.

The Medicare facility specific amount is \$40.56 multiplied by 200% for a MAR of \$81.12.

- Procedure code 96375 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is \$40.87. This is multiplied by 60% for an unadjusted labor amount of \$24.52, in turn multiplied by facility wage index 0.9873 for an adjusted labor amount of \$24.21.

The non-labor portion is 40% of the APC rate, or \$16.35.

The sum of the labor and non-labor portions is \$40.56.

The Medicare facility specific amount is \$40.56 multiplied by 200% for a MAR of \$81.12.

- Procedure code 96376 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code 99285 has status indicator J2 when billed in combination with more than 8 hours of observation. Review of the medical bill found the criteria for comprehensive observation are not met. This code is assigned APC 5025 with a status indicator of V.

The OPPS Addendum A rate is \$533.27 multiplied by 60% for an unadjusted labor amount of \$319.96, in turn multiplied by facility wage index 0.9873 for an adjusted labor amount of \$315.90.

The non-labor portion is 40% of the APC rate, or \$213.31.

The sum of the labor and non-labor portions is \$529.21.

The Medicare facility specific amount is \$529.21 multiplied by 200% for a MAR of \$1,058.42.

- Procedure code 90715 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 J1170 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.

3. The total recommended reimbursement for the disputed services is \$1,635.34. The insurance carrier paid \$0.00. The amount due is \$1,635.34. 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 requestor has established that additional reimbursement of \$1635.34 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 MHHS Hermann Hospital \$1635.34 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

		May 17, 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).