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

General Information

Requestor Name
University Medical Center

Respondent Name
Norguard Insurance Co

MFDR Tracking Number
M4-23-2696-01

Carrier's Austin Representative
Box Number 12

DWC Date Received
June 22, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 11-15, 2022	250	$0.00	$0.00
November 11-15, 2022	272	$0.00	$0.00
November 11-15, 2022	278	$0.00	$0.00
November 11-15, 2022	300	$0.00	$0.00
November 11-15, 2022	301	$0.00	$0.00
November 11-15, 2022	307	$0.00	$0.00
November 11-15, 2022	320	$0.00	$0.00
November 11-15, 2022	360	$2880.08	$2880.08
November 11-15, 2022	370	$0.00	$0.00
November 11-15, 2022	636	$0.00	$0.00
November 11-15, 2022	710	$0.00	$0.00
November 11-15, 2022	730	$0.00	$0.00
November 11-15, 2022	761	$0.00	$0.00
	Total	$2880.08	$2880.08

Requestor's Position

"It is written in the law that if the Provider request separate reimbursement for implants, the submission must be accompanied by certified invoices. However, we did not request they be paid separately, therefore, they should have been included in the MAR value at the higher rate of

200%. CPT code 25350 is the payable code. The payment rate is $5699.59 x wage index 0.8555 = $10410.87. Carrier paid $7530.79 leaving a balance due of $2880.08 and this is the amount of our dispute."

Amount in Dispute: $2880.08

Respondent's Position

The Austin carrier representative for Norguard Insurance Co is Shanley Price LLP. The representative was notified of this medical fee dispute on June 27, 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:

- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 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.

Issues

1. Did the requestor seek separate reimbursement of the implants?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in November of 2022. The insurance carrier reduced the payment as if separate reimbursement of the implants used during the surgery were requested.

   Review of the submitted medical bill found no indication the requestor sought separate reimbursement. The insurance carrier's reduction is not supported. The disputed service will be reviewed per applicable fee guideline.

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, 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 25415 has a status indicator of J1 and a ranking of 421. As the highest ranked J1 code all other codes are packaged into this comprehensive procedure.

  This code is assigned APC 5114. The OPPS Addendum A rate is $6,397.05 multiplied by 60% for an unadjusted labor amount of $3,838.23, in turn multiplied by facility wage index 0.8372 for an adjusted labor amount of $3,213.37.

  The non-labor portion is 40% of the APC rate, or $2,558.82.

  The sum of the labor and non-labor portions is $5,772.19.

  The Medicare facility specific amount is $5,772.19 multiplied by 200% for a MAR of $11,544.38.

3. The total recommended reimbursement for the disputed services is $11,544.38. The insurance carrier paid $7,530.79. The requestor is seeking $2,880.08.. 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 $2,880.08 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 Norguard Insurance Co must remit to University Medical Center $2,880.08 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	August 24, 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.