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

General Information

Requestor Name
Texas Spine and Joint Hospital

Respondent Name
American Casualty Co of Reading

MFDR Tracking Number
M4-23-2891-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
July 13, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 9, 2023	0250	$74.50	$0.00
January 9, 2023	0255	$75.80	$0.00
January 9, 2023	0258	$15.25	$0.00
January 9, 2023	0270	$24.00	$0.00
January 9, 2023	0361	$6141.00	$1,538.18
January 9, 2023	0370	$4348.00	$0.00
January 9, 2023	0710	$417.00	$0.00
	Total	$11,095.55	$1,538.18

Requestor's Position

"Our position is that the bill is clearly payable and the Hospital is entitled to reimbursement, due to the representatives made by the claims adjuster."

Amount in Dispute: $11,095.55

Respondent's Position

The Austin carrier representative for American Casualty Co of Reading is Continental Casualty Co.

The representative was notified of this medical fee dispute on July 18, 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:

- 50 – These are non-covered services because this is not deemed a medical necessity by the payer.
- N661 – Documentation does not support that the services rendered were medically necessary.
- P1 – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered "reasonable or necessary". The amount adjusted is generally not the patient's responsibility, unless the workers' compensation state law allows the patient to be billed.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 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.
- W3 – Bill is a reconsideration or appeal.

Issues

1. Did the requestor receive required prior authorization?
2. Is the insurance carrier liable for the reimbursement of the disputed services?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of outpatient hospital services. DWC Rule 28 §134.600 (p) (2) states in pertinent part, non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services…

   Review of the submitted documentation found.

   - November 28, 2022 an email was sent by LaToya.Taylor@sedgwick.com that states, "Brenda per our conversation this morning, I am giving authorization and approval in writing for this patient to have her cortisone injections prescribed by pain management doctor.
   - January 4, 2023 an email was sent from the same Sedgwick employee, "Brooke I am giving written authorization and approval for patient (claimant) to have her shots requested.
   - January 4, 2023 an email was sent to same Sedgwick employee asking, "Please tell me what CPT codes are included in this approval as well as what hospital is approved."

     Sedgwick employee responded, "Texas Spine and Joint, CODES N 644893, 64484, Lt, L4, L5, Sel ESI.

   Based on this review, the requestor did receive prior authorization for the disputed services as required by Rule §134.600.

2. DWC Rule 28 TAC §134 (c) (1) (B) states, The insurance carrier is liable for all reasonable and necessary medical costs relating to the healthcare listed in subsection (p) or (q) of this section that was approved prior to providing the health care.

   As shown above, the requestor did receive approval for the disputed services prior to providing the health care.

   DWC Rule 28 TAC §134.600 (l) states, The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued. The approval shall include the specific health care.

   Review of the submitted emails from the Sedgwick representative approved the specific services at the facility where the services were rendered.

   The insurance carrier's denials are not supported and will not be considered in this review.

3. 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 64483 LT KX has status indicator T. This code is assigned APC 5443. The OPPS Addendum A rate is $852.18 multiplied by 60% for an unadjusted labor amount of $511.31, in turn multiplied by facility wage index 0.8375 for an adjusted labor amount of $428.22.

     The non-labor portion is 40% of the APC rate, or $340.87.

     The sum of the labor and non-labor portions is $769.09.

     The Medicare facility specific amount is $769.09 multiplied by 200% for a MAR of $1,538.18.

   - Procedure code 64484 LT KX 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 $1,538.18. 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 $1,538.18 for the disputed services. It is ordered that American Casualty Co of Reading PA must remit to Texas Spine and Joint Hospital $1,538.18 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	September 7, 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.