TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Providence Sierra

Respondent Name
City of El Paso

MFDR Tracking Number
M4-23-3164-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 15, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 19, 2022	24342-RT	$4,353.76	$0.00
	Total	$4,353.76	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "Per the terms of our agreement governing CLAIMS ADMINISTRATIVE effective 03/01/2008, our expected contract allowable is based on: Pass-throughs("Drug" or "Implant" "MRI") Based on this/these services(s), the expected reimbursement amount is $16,509.60. ...Revenue Code 278 charges are reimburse as charges in service type $46,704.00 exceeds threshold of $3,000.00 then cost + less of 10 percent of $1,000 per item not to exceed $2,000.00 per admission with reimbursement of $5,778.36. OPSurg Implants greater than $3,000 are payable at 130% of Standard Medicare OPPS pricing in the amount of $10,731.24. Hospitals of Providence – Sierra is requesting CLAIMS ADMINISTRIV review implantable TDI-DWC rules; updated claim and reprocess and issue the additional $4,353.76 due on Outpatient Implantables."

Amount in Dispute: $4,353.76

Respondent's Position

"The initial billing received did not document separate implant reimbursement was being requested. As such, payment was issued at 200% of Medicare facility reimbursement. The provider refiled appearing to request separate implant reimbursement. There were 2 implant fees billed and after calculated cost plus 10% of these 2 implants, in addition to 130% of Medicare facility reimbursement for the balance of the bill, payment would have been less than our original reimbursement. I have attached copies of the 2 implant invoices marked with an X by the facility. It is our position payment issued was correct and no further reimbursement would be due."

Response submitted by: Claims Administrative Services, Inc.

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:

- 5 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 7 P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.

Issues

1. What services are in dispute?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor has submitted a DWC60 for Code 24342, RT – Repair of ruptured tendon surgical procedure for date of service August 19, 2022. The insurance carrier reduced their payment amount based on the workers' compensation fee schedule.

   The requestor included a copy of their request for reconsideration that was asking for separate reimbursement of implants. The codes for implants were not listed on the DWC60 and will not be considered in this review. Additionally, the request for reconsideration mentioned contract terms. Insufficient evidence was found to support a contract exists between the two parties.

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 24342 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 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 0.8249 for an adjusted labor amount of $3,166.16.

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

The sum of the labor and non-labor portions is $5,724.98.

The Medicare facility specific amount is $5,724.98 multiplied by 200% for a MAR of $11,449.96.

3. The total recommended reimbursement for the disputed services is $11,449.96. The insurance carrier paid $12,155.84. 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 14, 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.