



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Regional Medical Center

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-23-3309-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 11, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 16, 2022	23655	\$194.95	\$190.84
	Total	\$194.95	\$190.84

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" addressed to the Texas Department of Insurance. Request for reconsideration must be sent to the correct workers' compensation carrier not TDI. "This document states, "According to TX workers compensation fee schedule the expected reimbursement for CPT code 23655 is \$2,768.55. Please note that Outpatient services should be reimbursed at 200% per Medicare rate. Previous payment received totaled \$2,573.60. Please reprocess and remit payment for remaining balance due."

Amount in Dispute: \$194.95

Respondent's Position

"The carrier's reimbursement amount is correct. We are attaching a copy of the calculation that led to the reimbursement amount of \$2,573.60. We are also attaching the carrier's EOR's dated

January 25, 2023 and June 23, 2023. The first EOR recommended payment of \$2,573.60. The second EOR recommended no additional payment.”

Response submitted by: Flahive, Ogden & Latson

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:

- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is package or excluded from payment.
- 56 – Significant, separately identifiable E/M service rendered.
- 802 – Charge for this procedure exceeds the OPPI schedule allowance.
- 97 – Payment adjusted because 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.

Issues

1. What rule is applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in December of 2022. The insurance carrier reduced the payment based on packaging and fee schedules.

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 23655 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 5112. The OPPS Addendum A rate is \$1,422.51 multiplied by 60% for an unadjusted labor amount of \$853.51, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of \$813.22.

The non-labor portion is 40% of the APC rate, or \$569.00.

The sum of the labor and non-labor portions is \$1,382.22.

The Medicare facility specific amount is \$1,382.22 multiplied by 200% for a MAR of \$2,764.44.

2. The total recommended reimbursement for the disputed services is \$2,764.44. The insurance carrier paid \$2,573.60. The amount due is \$190.84. 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 Texas Regional Medical Center must remit to Zurich American Insurance Co \$190.84 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 29, 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 electrónico CompConnection@tdi.texas.gov.