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

General Information

Requestor Name
Texas Regional Medical Center

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-24-0419-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 18, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 9, 2023	28485	$0.00	$0.00
March 9, 2023	80053	$13.20	$0.00
March 9, 2023	81025	$10.76	$0.00
March 9, 2023	C1713	$6444.27	$0.00
March 9, 2023	C1781	$3027.00	$0.00
	Total	$4721.17	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR). They did submit a copy of their reconsideration that states, "This clean claim was billed requesting the surgical procedure be paid at 130% of CMS with separate reimbursement for our implants. **According to Texas Workers Compensation Rule 134.402, 'Implantable devices are reimbursed at the providers cost plus 10% up to $1,000.00 per item or $2,000.00 per case.'**"

Amount in Dispute: $4,721.17

Respondent's Position

"The carrier already reimbursed the provider $12,854.60. Based upon the documents that were submitted to the carrier prior to the filing of the DWC 60 do not support any additional payments."

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 §133.10 sets out the billing requirements for outpatient medical bills.
3. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 1003 – In response to your appeal of our previous re-evaluation, no significant additional documentation or information regarding this claim has been received. Our position remains unchanged on the same questions that were previously posed by the provider. Therefore, no additional allowance is recommended.
- 1126 – This reconsideration reflects corrected charge amount.
- 5420 – The procedure was reviewed according to the submitted report. Please note the number of units were changed according to the performed service/time/qty.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- P13 – Payment reduced or denied based on Workers' compensation jurisdictional regulations or payment polices.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 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 of the payment status indicator determines the service is packaged or excluded from payment.

- 802 – Charge for this procedure exceeds the OPPS 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.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.

Issues

1. Is the requestors' position statement supported?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor states in their position statement, "This clean claim was billed requesting the surgical procedure be paid at 130% of CMS with separate reimbursement for our implants." DWC Rule 28 TAC §133.10 (f)(2)(QQ) states, "remarks (UB-04.field 80) is required when separate reimbursement for surgically implanted devices is requested."

   Review of the submitted medical bill found no request for separate implant reimbursement was made. DWC Rule 28 TAC §134.403(f) states in part that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount…multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement…" As the requestor did not request separate reimbursement on the original bills, the reimbursement will be the Medicare facility specific amount multiplied by 200 percent. The requestor s position is not supported.

2. The requestor is seeking payment for charges rendered during a surgical procedure performed in an outpatient hospital setting on March 9, 2023.

   DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants to apply Medicare payment policies in effect on the date of service for coding, billing, reporting, and reimbursement.

   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.,

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 28485 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 $6,614.63 is multiplied by 60% for an unadjusted labor amount of $3,968.78, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $3,781.45.

  The non-labor portion is 40% of the APC rate, or $2,645.85.

  The sum of the labor and non-labor portions is $6,427.30.

  The Medicare facility specific amount is $6,427.30 multiplied by 200% for a MAR of $12,854.60.

- Procedure code 80053 has a status indicator of Q4 and is bundled into the primary J1 procedure Code 28485.

- Procedure code 81025 has a status indicator of Q4 and is bundled into the primary J1 procedure Code 28485.

3. The total recommended reimbursement for the disputed services is $12,854.60. The insurance carrier paid $12,854.60. 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 additional reimbursement is due.

Order

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

Authorized Signature

		February 2, 2024
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.