



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

North Central Baptist
Medical Center

Respondent Name

North East ISD

MFDR Tracking Number

M4-24-1163-01

Carrier's Austin Representative

Box Number 55

DWC Date Received

January 25, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 3, 2023	0250	\$596.00	\$0.00
March 3, 2023	0278	\$334.64	\$0.00
March 3, 2023	0300	\$617.00	\$0.00
March 3, 2023	0320	\$1,747.00	\$0.00
March 3, 2023	0360	\$33,056.00	\$0.00
March 3, 2023	0370	\$6,393.00	\$0.00
March 3, 2023	0424	\$666.00	\$0.00
March 3, 2023	0636	\$1,147.50	\$0.00
March 3, 2023	0710	\$16,708.00	\$0.00
March 3, 2023	WC ADJUSTMENT	\$-48,924.68	\$0.00
Total		\$12,340.46	\$0.00

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Sedgewick, but the bill was denied. However, despite the Hospital's efforts and Request for Reconsideration Sedgewick has not rendered proper payment or denial within forty-five (45) days of the insurance carrier having received the bill in accordance with the Texas Administrative Code §133.240(a).

Amount in Dispute: \$12,340.46

Respondent's Position

"The providers billed for a surgery involving a non-compensable condition which is not owed by the Carrier and the bill should be submitted to the Claimant and/or her group health insurance carrier."

Response submitted by: Christopher J. Ameel Attorney at Law

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 Texas Administrative Code \(TAC\) §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 disputed service(s) with the following claim adjustment codes.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P14 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
- Comments – Corrected billing submitted. No additional payment due.

Issues

1. Did the respondent raise a new issue?
2. Does documentation support payment?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of an outpatient hospital surgery rendered in March of 2023. The insurance carrier reduced the disputed service based on workers' compensation fee schedule and packaging.

Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution.

A review of the submitted information finds insufficient documentation to support that an EOB was presented to the health care provider, giving notice of the compensability denial reasons or defenses raised in the insurance carrier's response to MFDR.

Rule §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

2. The requestor did not reference a payment was made on the disputed service. Review of the submitted documentation submitted with this request for MFDR found.

- Explanation of benefits (EOB) dated April 12, 2023. Allowed amount \$12,331.86
- Reconsideration EOB dated April 2023. Prior payment \$12,331.86. Recommended payment \$0.00 with comment, "No additional payment due."

Based on the submitted documents, the DWC will review the disputed services per the applicable fee guidelines.

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 C1713 represents implants. Field 80 of the submitted medical bill did not contain a request for separate implant reimbursement. Separate payment is not recommended.
- Procedure code 81025 is packaged into comprehensive code 28308. Separate payment is not recommended.
- Procedure code 73620 is packaged into comprehensive code 28308. Separate payment is not recommended.
- Procedure code 28285 has a status indicator of J1. However, Medicare payment policy for comprehensive procedures allows payment to be made ONLY for the highest ranked procedure found at www.cms.gov, Addenda J. The ranking of code 28285 is 2,022. The ranking of code 28308 is 1,894. Code 28308 is the highest ranked J1 code and will receive comprehensive reimbursement. Code 28285 is packaged into comprehensive code 28308. Separate payment is not recommended.
- Procedure code 28308 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5113. The OPPS Addendum A rate is \$2,976.66 multiplied by 60% for an unadjusted labor amount of \$1,786.00, in turn multiplied by facility wage index 0.8631 for an adjusted labor amount of \$1,541.50.

The non-labor portion is 40% of the APC rate, or \$1,190.66.

The sum of the labor and non-labor portions is \$2,732.16.

The Medicare facility specific amount is \$2,732.16 multiplied by 200% for a MAR of \$5,464.32.

- Procedure code 97161 is packaged into primary comprehensive procedure. Separate payment is not recommended.
 - Procedure code J1100 has status indicator N reimbursement is included with payment for the primary services.
 - Procedure code J2250 has status indicator N reimbursement is included with payment for the primary services.
 - Procedure code J2704 has status indicator N reimbursement is included with payment for the primary services.
 - Procedure code J2795 has status indicator N reimbursement is included with payment for the primary services.
 - Procedure code J3010 has status indicator N reimbursement is included with payment for the primary services.
 - Procedure code J7050 has status indicator N reimbursement is included with payment for the primary services.
 - Procedure code J7120 has status indicator N reimbursement is included with payment for the primary services.
4. The total recommended reimbursement for the disputed services is \$5,464.32. The insurance carrier paid \$12,331.86. 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

Signature

Medical Fee Dispute Resolution Officer

February 26, 2024
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.