



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Northeast Baptist Hospital

**Respondent Name**

Church Mutual Insurance Company

**MFDR Tracking Number**

M4-24-1165-01

**Carrier's Austin Representative**

Box Number 17

**DWC Date Received**

January 25, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 21, 2023	0250	\$286.00	\$0.00
March 21, 2023	0278	\$6,014.80	\$0.00
March 21, 2023	0300	\$116.00	\$0.00
March 21, 2023	0320	\$1,280.00	\$0.00
March 21, 2023	0360	\$26,185.00	\$4,111.00
March 21, 2023	0370	\$5,114.00	\$0.00
March 21, 2023	0636	\$389.00	\$0.00
March 21, 2023	0710	\$7,604.00	\$0.00
	WC PAYMENTS	(\$7,892.70)	\$0.00
	WC ADJUSTMENT	-\$34,985.60	\$0.00
	<b>Total</b>	<b>\$4,111.00</b>	<b>\$4,111.00</b>

### Requestor's Position

"The Hospital billed Church Mutual, but the bill was underpaid and not paid in accordance with Chapter 134 regarding proper reimbursement for implantables. However, despite the Hospital's efforts and Request for Reconsideration to Church Mutual has not rendered proper payment."

**Amount in Dispute:** \$4,111.00

### Respondent's Position

The Carrier has paid a total of \$7,892.70. This amount was inclusive of the entire surgical procedure, the APC rate plus the markup. In conclusion, Requestor is not owed any additional reimbursement for the surgical procedure.”

**Response submitted by:** Downs♦Stanford, PC

## **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 §133.10](#) sets out the requirements of separate implant reimbursement.
3. [28 TAC §134.403](#) sets out the fee guidelines for outpatient hospital services.

### Denial Reasons

- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 - The value of this procedure is packaged into the payment/allowance for another service/procedure that has already been adjudicated.
- 97 – 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.
- P13 – Payment reduced or denied based on Workers’ compensation jurisdictional regulations or payment policies.
- U03 – The billed service was reviewed by UR and authorized.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 790 – This charge was reimbursed in accordance to the Texas medical fee guideline.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Note: Please submit bill (UB04) with implants invoice for reconsideration.

### Issues

1. Did the requestor seek separate reimbursement of implants?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

### Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in March 2023. The insurance carrier made a reduction based on the fee guideline and denied Revenue Code 278/Code C1713 for lack of document and certified invoice.

DWC Rule 28 TAC §133.10 (f)(2)(QQ) indicates (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested. Review of the submitted medical bill found field 80 does not contain a request for separate implant reimbursement.

The services in disputed will be calculated per the applicable fee guideline when separate implant reimbursement is not requested.

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](http://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)(1)(A)(B) states in pertinent parts 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 sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

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 an implant. Because the health care provider did not request separate reimbursement, payment is packaged into the primary procedure.
- Procedure code 82962 has a status indicator of Q4 and is packaged into the primary procedure.
- Procedure code 73560 has a status indicator of Q1 and is packaged into the primary procedure.
- Procedure code 27524 has a status indicator J1 and is paid at a comprehensive rate. All the remaining 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 multiplied by 60% for an unadjusted labor amount of \$3,968.78, in turn multiplied by facility wage index 0.8631 for an adjusted labor amount of \$3,425.45.

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

The sum of the labor and non-labor portions is \$6,071.30.

The Medicare facility specific amount is \$6,071.30 multiplied by 200% for a MAR of \$12,142.60.

- Procedure code J0690 has a status indicator N reimbursement is included with payment for the primary services.
  - Procedure code J2405 has a status indicator N reimbursement is included with payment for the primary services.
  - Procedure code J2704 has a status indicator N reimbursement is included with payment for the primary services.
  - Procedure code J2795 has a status indicator N reimbursement is included with payment for the primary services.
  - Procedure code J3010 has a status indicator N reimbursement is included with payment for the primary services.
  - Procedure code J7120 has a status indicator N reimbursement is included with payment for the primary services.
3. The total recommended reimbursement for the disputed services is \$12,142.60. The insurance carrier paid \$7,892.70. The requestor is seeking \$4,111.00. 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 Church Mutual Insurance Company must remit to Northeast Baptist Hospital \$4,111.00 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

February 29, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).