



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Spine and Joint Hospital

Respondent Name

Pennsylvania Manufacturers Association Insurance Co

MFDR Tracking Number

M4-24-1098-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

January 17, 2024

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|--------------------|--------------------|
| August 11, 2023 | C1820 | \$53,560.00 | \$0.00 |
| August 11, 2023 | 83036 | \$726.00 | \$0.00 |
| August 11, 2023 | 80048 QW | \$595.00 | \$0.00 |
| August 11, 2023 | 87081 | \$416.00 | \$0.00 |
| August 11, 2023 | 85027 | \$361.00 | \$0.00 |
| August 11, 2023 | 81003 QW | \$222.00 | \$0.00 |
| August 11, 2023 | 36415 | \$95.00 | \$0.00 |
| August 11, 2023 | 63685 | \$10,874.50 | \$52,992.06 |
| August 11, 2023 | 63650 | \$5,437.25 | \$0.00 |
| August 11, 2023 | 63650 XE | \$5,437.25 | \$0.00 |
| August 11, 2023 | J0171 | \$71.00 | \$0.00 |
| August 11, 2023 | G0463 25 | \$1,336.00 | \$0.00 |
| Total | | \$79,131.00 | \$52,992.06 |

Requestor's Position

"The Hospital's position is that the treatment was properly certified and the bill should not be denied for lacking preauthorization. The Hospital took all necessary steps to verify the Claimant's worker's compensation coverage and received the required preauthorization prior to providing treatment, as evidenced by the attached authorization certification from Genex, dated 4/28/23."

Supplemental response submitted March 13, 2024

"...as of today no payment has been received by Texas Spine & Joint Hospital on this bill."

Amount in Dispute: \$79,131.00

Respondent's Position

"...based upon additional information provided by the DWC 60 packet, the carrier is going to reprocess the provider's medical bill. If that results in a change in the carrier's position, we will supplement the current response with the additional information."

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 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §133.10](#) sets out the requirements for requesting separate reimbursement of implants.
3. [28 TAC §134.600](#) sets out the requirements of prior authorization.
4. [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.

- UT – The service provided is not authorized under this Workers' Compensation injury
- 5225 – Procedure/Services are disallowed as they are not authorized.
- 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.
- 247 – A payment or denial has already been recommended for this service.
- 295 – Service cannot be reviewed without report or invoice. Please submit report/invoice

as soon as possible to ensure accurate processing.

Issues

1. Was prior authorization required?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment for outpatient hospital services rendered in August of 2023. The insurance carrier denied the service based on lack of prior authorization.

DWC Rule 28 TAC §134.600 (p)(2) states in pertinent parts, "Non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services as defined in subsection (a)..."

Review of the submitted documentation found an URA Review from Genex dated April 28, 2023, with the recommendation to CERTIFY a spinal cord stimulatory permanent placement.

The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

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)(2) states in pertinent part, **regardless of billed amount**, if no contracted fee schedule exists that complies with Labor Code §413.011, 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 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. Review of the submitted medical bill found a request for implants was not made in box 80 of the submitted medical bill. The Medicare facility specific reimbursement amount will be multiplied by 200 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 C1820 – G3enerator, neurostimulator (implantable). DWC Rule §133.20 (2)(QQ) states, "UB-04/field 80 is required when separate reimbursement for surgically implanted device is requested. Review of the submitted medical bill found the medical bill did not contain a request for separate reimbursement of implants as required by applicable DWC rule. No separate payment is recommended.
- Procedure code 83036 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code 80048 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code 87081 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code 85027 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code 81003 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code 36415 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code 63685 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 5465. The OPSS Addendum A rate is \$29,358.48 multiplied by 60% for an unadjusted labor amount of \$17,615.09, in turn multiplied by facility wage index 0.8375 for an adjusted labor amount of \$14,752.64.

The non-labor portion is 40% of the APC rate, or \$11,743.39.

The sum of the labor and non-labor portions is \$26,496.03.

The Medicare facility specific amount is \$26,496.03 multiplied by 200% for a MAR of \$52,992.06.

- Procedure code 63650 is a lower ranked J1 code that is packaged into the primary code above.
- Procedure code 63650 XE is a lower ranked J1 code that is packaged into the primary code 63685.

- Procedure code J0171 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
 - Procedure code G0463 has a status indicator of V and is packaged into the primary procedure 63650.
3. The total recommended reimbursement for the disputed services is \$52,992.06. The insurance carrier paid \$0.00. The amount due is \$52,992.06. 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 Pennsylvania Manufacturers Association must remit to Texas Spine and Joint Hospital \$52,992.06 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

| | | |
|-----------|--|---------------|
| | | April 3, 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 electrónico CompConnection@tdi.texas.gov.