TDI Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Providence Sierra

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-24-1313-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 6, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 1, 2023	250 PHARMACY	Left blank	$0.00
June 1, 2023	278 SUPPLY/IMPLANTS	Left blank	$0.00
June 1, 2023	278 SUPPLY/IMPLANTS	Left blank	$0.00
June 1, 2023	320 DX X-RAY	Left blank	$0.00
June 1, 2023	360 OR SERVICES	Left blank	$0.00
June 1, 2023	360 OR SERVICES	Left blank	$0.00
June 1, 2023	370 ANESTHESIA	Left blank	$0.00
June 1, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
June 1, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
June 1, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
June 1, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
June 1, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
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June 1, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
June 1, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
June 1, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
June 1, 2023	710 RECOVERY ROOM	Left blank	$0.00
	Total	$3,370.34	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated September 20, 2023 that states, "This claim was denied due to lack of authorization for the services rendered. Services provided were medically necessary in order to provide an effective course of treatment, avoid an adverse occurrence, and/or prevent readmission. We disagree with the denial reason because the requirement(s) for authorization was satisfied, as explained below. …In this case in particular, we were not aware that the services rendered required authorization."

Amount in Dispute: $3,370.34

Respondent's Position

"The carrier cannot understand the basis that the provider's disagreement with the reimbursement amount of $12,142.60. The provider certainly has not explained why any additional payments are owed. It remains the carrier's position that it fully reimbursed the provider."

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 §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.

- 197 – Payment denied/reduced for absence of precertification/authorization
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 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.

- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 2008 – Additional payment made on appeal/reconsideration.
- 5463 – Paid in accordance with Tenet Health System Employee Network.
- 6060 – Based on additional information from the claims examiner, we are recommending further payment be made for the above noted procedure code/codes.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal.

Issues

1. Did the insurance carrier maintain their original denial?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in June of 2023. The insurance carrier denied the disputed service for lack of prior authorization. Upon reconsideration, the insurance carrier made a payment based on the workers' compensation fee schedule. The requestor filed for MFDR seeking an additional payment. The maximum allowable reimbursement fee calculated is found below.
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 exits 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 applies.

   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 no request for separate reimbursement of implants. The Medicare facility specific 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 C1713 has status indicator N for packaged codes integral to the total service package with no separate payment when separate reimbursement is not requested.

- Procedure code C1762 has status indicator N, for packaged codes integral to the total service package with no separate payment when separate reimbursement is not requested.

- Procedure code 73030 has a Q1 status indicator and is packaged into the primary J1 procedure. No separate payment is recommended.

- Procedure code 24685 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 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 64450 has a status indicator of T and is packaged into primary J1 procedure. No separate payment is recommended.

- Procedure code J0330 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J0690 has status indicator N for packaged codes integral to the total service package with no separate payment.
- Procedure code J1100 has status indicator N for packaged codes integral to the total service package with no separate payment.
- Procedure code J1885 has status indicator N for packaged codes integral to the total service package with no separate payment.
- Procedure code J2250 has status indicator N for packaged codes integral to the total service package with no separate payment.
- Procedure code J2405 has status indicator N for packaged codes integral to the total service package with no separate payment.
- Procedure code J2704 has status indicator N for packaged codes integral to the total service package with no separate payment.
- Procedure code J2765 has status indicator N for packaged codes integral to the total service package with no separate payment.
- Procedure code J2795 has status indicator N for packaged codes integral to the total service package with no separate payment.
- Procedure code J3010 has status indicator N for packaged codes integral to the total service package with no separate payment.
- Procedure code J7120 has status indicator N for packaged codes integral to the total service package with no separate payment.

3. The total recommended reimbursement for the disputed services is $12,142.60. The insurance carrier paid $12,142.60. 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled

to $0.00 reimbursement for the disputed services.

Authorized Signature

[redacted] Medical Fee Dispute Resolution Officer — March 15, 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 electronico CompConnection@tdi.texas.gov.