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

General Information

Requestor Name
Northeast Baptist Hospital

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-24-1403-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 27, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 21 – 23, 2023	0250	553.00	$0.00
March 21 – 23, 2023	0278	12178.00	$0.00
March 21 – 23, 2023	0300	1711.00	$0.00
March 21 – 23, 2023	0360	51009.00	$4,784.01
March 21 – 23, 2023	0370	8951.00	$0.00
March 21 – 23, 2023	0636	3414.00	$0.00
March 21 – 23, 2023	0710	9880.00	$0.00
March 21 – 23, 2023	0730	961.00	$0.00
March 21 – 23, 2023	WC PAYMENTS	-9568.05	$0.00
March 21 – 23, 2023	WC ADJUSTMENTS	-72166.00	$0.00
	Total	$6922.85	$4,784.01

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 CRS, but the bill was underpaid and not paid in reimbursed appropriately. However, despite the Hospital's efforts and Request for Reconsideration to CRS on July 4, 2023, and February 12, 2024 (incorrectly dated as 2023 due to a typo), CRS has not rendered proper payment."

Amount in Dispute: $6922.85

Respondent's Position

The Austin carrier representative for Aurich American Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on March 5, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response submitted by: N/A

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.
3. 28 TAC §133.10 sets out requirements of separate implant reimbursement requirements.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 1A – A copy of an invoice showing the cost of the implant, supplies/materials, device or durable medical equipment must be received. The invoice must be specific to the patient, show cost of acquisition, and/or cost of the product or equipment.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- CBRH – Complex Hospital / ASC bill review.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P14 – The service is considered incidental, packaged, or bundled into another service or APC payment.
- PS – The charge exceeds the APC rate for this service.

Issues

1. What rule is applicable to reimbursement?

2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of outpatient hospital services rendered in March of 2023. The insurance carrier reduced the disputed service based on the workers' compensation fee schedule. The services in dispute will be reviewed per applicable fee guidelines.

   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.

   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.

   DWC Rule 28 TAC §133.10 (2) (QQ) states, "The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care: (QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."

   Review of the submitted medical bill found box 80 of the UB-04 with creation date of March 29, 2023 did not contain a request for separate reimbursement of implants. The submitted DWC 60 indicates an amount in dispute for Revenue code 278. However, the requirements of Rule 133.10 (2)(QQ) were not met. No separate reimbursement of the implants will be considered.

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 C1781 (Revenue Code 278) 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 when no separate reimbursement requested per DWC guidelines.

- Procedure code 80048 (Revenue Code 300) is included with payment for the primary procedure. Separate payment is not recommended.

- Procedure code 82962 (Revenue Code 300) is included with payment for the primary procedure. Separate payment is not recommended.

- Procedure code 85025 (Revenue Code 300) is included with payment for the primary procedure. Separate payment is not recommended.

- Procedure code 49650 -50 (Revenue Code 360) 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 5361. This code is assigned APC 5361. The OPPS Addendum A rate is $5,212.15 multiplied by 150% for bilateral procedure equals $7,818.22. This is multiplied by 60% for an unadjusted labor amount of $4,690.93, in turn multiplied by facility wage index 0.8631 for an adjusted labor amount of $4,048.74.

  The non-labor portion is 40% of the APC bilateral rate, or $3,127.29.

  The sum of the labor and non-labor portions is $7,176.03.

  The Medicare facility specific amount is $7,176.03 multiplied by 200% for a MAR of $14,352.06.

- Procedure code C9290 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.

- Procedure code J0131 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.

- Procedure code J0330 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.

- Procedure code J0690 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.

- Procedure code J1100 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J1170 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J2250 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J2405 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J2704 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J2710 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J3010 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J7120 (Revenue Code 636) has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code 93005, (Revenue Code 730) billed March 21, 2023, has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for primary service.

2. The total recommended reimbursement for the disputed services is $14,352.06. The insurance carrier paid $9,568.05. The amount due is $4,784.01. 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 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 Zurich American Insurance Co must remit to Northeast Baptist Hospital $4,784.01 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	April 30, 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.