



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Midland Memorial Hospital

**Respondent Name**

Zurich American Insurance Co

**MFDR Tracking Number**

M4-24-1591-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

March 20, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 11 – 13, 2023	Outpatient Procedure	\$8,156.47	\$8,156.47
<b>Total</b>		\$8,156.47	\$8,156.47

### Requestor's Position

"This bill has been underpaid."

**Amount in Dispute:** \$8,156.47

### Respondent's Position

"The provider billed \$51,047.03. The provider acknowledge that the carrier had already paid it the amount of \$15,305.64. The provider is seeking additional payment of \$8,156.47."

**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.

- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- 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.
- 18 – Exact duplicate claim/service.

### Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

### Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in August of 2023. The insurance carrier reduced the charges based on packaging need of documentation and workers' compensation fee schedule.

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)(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. 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 20694 has status indicator Q2 and is packaged into primary J1 comprehensive procedure shown below.
- Procedure code 27827 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 5115. The OPPS Addendum A rate is \$13,048.08 multiplied by 60% for an unadjusted labor amount of \$7,828.85, in turn multiplied by facility wage index 0.8372 for an adjusted labor amount of \$6,554.31.

The non-labor portion is 40% of the APC rate, or \$5,219.23.

The sum of the labor and non-labor portions is \$11,773.54.

The Medicare facility specific amount is \$11,773.54 multiplied by 200% for a MAR of \$23,547.08.

2. The total recommended reimbursement for the disputed services is \$23,547.08. The insurance carrier paid \$15,305.84. The requestor is seeking additional reimbursement of \$8,156.47. 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 requestor 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 Zurich American Insurance Co must remit to Midland Memorial Hospital \$8,156.47 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

_____	_____	April 11, 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](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).