TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Texas Spine and Joint Hospital

Respondent Name
Employers Preferred Insurance Co

MFDR Tracking Number
M4-24-1721-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
April 10, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 24, 2023	C1713	13390.00	Included below
October 24, 2023	85610	641.00	Included below
October 24 – 26, 2023	80048 QW X3	1785.00	Included below
October 24, 2023	84703	433.00	Included below
October 24, 2023	87081	416.00	Included below
October 24 – 26, 2023	85027 X3	1083.00	Included below
October 24, 2023	94010	592.00	Included below
October 24, 2023	J0171	71.15	Included below
October 24, 2023	G0463 25	1336.00	Included below
October 24, 2023	G0378	6394.00	Included below
October 24, 2023	81001 QW	293.00	Included below
October 24, 2023	36415	95.00	Included below
October 24, 2023	36415	95.00	Included below
October 25, 2023	3415	95.00	Included below
October 26, 2023	36415	95.00	Included below
October 24, 2023	82962	5.00	Included below
October 24, 2023	72100 TC	800.00	Included below
October 24, 2023	22630	21441.00	39,525.22
October 24, 2023	20939 RT	4288.20	Included above

October 24, 2023	22853	4288.20	Included above
October 24, 2023	20930	4288.20	Included above
October 24, 2023	20936	4288.20	Included above
October 24, 2023	20937 RT	4288.20	Included above
October 24, 2023	94664	470.00	Included above
October 25, 2023	94530 GP CQ	790.00	Included above
October 25, 2023	97110 GP CQ	772.00	Included above
October 25, 2023	97116 GP CQ	674.00	Included above
October 24, 2023	97162 GP	428.00	Included above
October 24, 2023	97530 GP	395.00	Included above
October 24, 2023	97112 GP	395.00	Included above
October 24, 2023	97530 GP	395.00	Included above
October 24, 2023	97110 GP	386.00	Included above
October 26, 2023	97110 GP	386.00	Included above
October 24, 2023	9711659 GP	337.00	Included above
October 26, 2023	9711659 GP	337.00	Included above
	Total	76,266.15	39,525.22

Requestor's Position

"The Hospital contends that the bill is incorrectly denied as a duplicate. The Hospital billed Employers for this service on one occasion-via certified mail on 11/8/2023. Employers received the bill on 1/8/2024 and processed/denied it on 1/18/2024. No previous bill had been submitted for this treatment, and the only other time Employers received correspondence concerning the bill was the request for reconsideration submitted by this office on the Hospital's behalf. In that correspondence, this office also requested the original Explanation of Bill Review reflecting where the 10/24/2023 DOS had been previously reviewed and adjudicated; however, no responsive documents were provided. The Hospital received no prior EORs or other documentation indicating that this DOS had been previously audited."

Respondent's Position

"It has been determined that no allowance is due and the bill was processed correctly. The Denial of this bill is correct as a single payment has already been made."

Response submitted by: Conduent

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 billing requirements when implant reimbursement is requested.

Denial Reasons

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

- 29 – The time limit for filing has expired.
- 4271 – Per TX Labor Code Sec. 408.027. Providers must submit bills to payors within 95 days of the date of service.
- 5280 – No additional reimbursement allowed after review of appeal/reconsideration.
- W3 – Bill is a reconsideration of appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on the 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.
- 16 – Exact duplicate claim/service.
- 309 – Billing is a duplicate of other services performed on same day.

Issues

1. Is the respondent's position statement supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of outpatient hospital service rendered in October of 2023. The insurance carrier denied these charges as a duplicate and then for timely filing. The respondent states in their position statement, "The Denial of this bill is correct as a single payment has already been made." Review of the submitted documentation did not support a payment was made. The respondent's position statement is not supported. Additionally, the respondent denied the claim for untimely submission of the medical bill.

Review of the submitted documentation found the "process date" of the EOR was dated January 18, 2024. This date is within 95 days of the date of service October 24, 2023. The respondent's denial is not supported. The disputed service will be reviewed per applicable fee guidelines.

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.

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 (f)(2)(QQ) states in pertinent parts, "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."

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 C1713 has status indicator N no separate reimbursement requested. Reimbursement is included with payment for the primary services.
- Procedure code 85610 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.

- Procedure code 80048 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Per Medicare policy, procedure code 80048, billed October 25, 2023, may not be reported with another code billed on this same claim. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code 80048, billed October 26, 2023, has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 84703 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 87081 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 85027 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 85027, billed October 25, 2023, has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 85027, billed October 26, 2023, has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 81001 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 36415 has status indicator Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 36415 has status indicator Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 36415, billed October 25, 2023, has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 36415, billed October 26, 2023, has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 82962 has a status indicator of Q4. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 72100 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code 22630 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 5116. The OPPS Addendum A rate is $21,897.63 multiplied by 60% for an unadjusted labor amount of $13,138.58, in turn multiplied by facility wage index 0.8375 for an adjusted labor amount of $11,003.56.

The non-labor portion is 40% of the APC rate, or $8,759.05.

The sum of the labor and non-labor portions is $19,762.61.

The Medicare facility specific amount is $19,762.61 multiplied by 200% for a MAR of $39,525.22.

- Procedure code 20939 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 22853 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 20930 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 20936 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 20937 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 94664 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for primary service.
- Procedure code 97530, billed October 25, 2023, has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 97110, billed October 25, 2023, has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 97116, billed October 25, 2023, has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 97162 has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 97530 has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.

- Procedure code 97112 has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 97530, billed October 26, 2023, has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 97110 has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 97110, billed October 26, 2023, has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 97116 has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 97116, billed October 26, 2023, has a status indicator of A. Reimbursement for this is included with payment for the primary procedure.
- Procedure code 94010 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for primary procedure.
- 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 J2. Reimbursement for this is included with payment for the primary procedure.
- Procedure code G0378 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.

3. The total recommended reimbursement for the disputed services is $39,525.22. The insurance carrier paid $0.00. The amount due is $39,525.22. 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 Employers Preferred Insurance Co must remit to Texas Spine and Joint Hospital $39,525.22 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 9, 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 electronico CompConnection@tdi.texas.gov.