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
Northeast Baptist Hospital

Respondent Name
Phoenix Insurance Co

MFDR Tracking Number
M4-24-1919-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
May 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 28, 2023	0250	407.00	All inclusive
August 28, 2023	0278	12178.00	All inclusive
August 28, 2023	0300	1595.00	All inclusive
August 28, 2023	0360	34037.40	4,893.46
August 28, 2023	0370	7672.00	All inclusive
August 28, 2023	0636	3703.00	All inclusive
August 28, 2023	0710	9880.00	All inclusive
August 28, 2023	0730	961.00	All inclusive
August 28, 2023	WC ADJUSTMENTS	-63401.10	
	Total	$7032.30	$4,893.46

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 Travelers, but the bill was underpaid and not paid in accordance with Chapter 134 regarding proper reimbursement for implantables. However, despite the Hospital's efforts and Request for Reconsideration Travelers has not rendered proper payment."

Amount in Dispute: $7,032.30

Respondent's Position

"The Carrier has reviewed the documentation and contends the Provider has been reimbursed at the over the correct amount per the applicable Division-adopted fee schedule. The Carrier has reviewed the Maximum Allowable Reimbursement calculation and contends the reimbursement should be $6,445.09 which creates an overpayment based on the reimbursement issued of $9,458.60. The Carrier contends the Provider is not entitled to additional reimbursement. The Carrier, therefore, respectfully requests the Division determine no additional reimbursement is due for this service."

Response submitted by: The Travelers

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 the billing requirements when requesting implant reimbursement.

Denial Reasons

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

- 97 – Payment adjusted because 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.
- 96 – Non-covered charge(s).
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 892 - Charge for this procedure exceeds the OPPS schedule allowance.
- 582 – Based on Medicare schedule, status indicates this code is either an invalid or delete CPT/HCPCS code. Medicare uses another code for reporting of, and payment for, this code. Please re-submit the appropriate code to ensure accurate processing.

- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

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 for outpatient hospital services rendered in August of 2023. The insurance carrier reduced the disputed charges based on packaging 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, 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. 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.

- Revenue code 0250 is listed on the DWC60. This revenue code is related to pharmacy charges. The Medicare Claims Processing Manual, Chapter 4, Section 10.4, (Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18) states, *"Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part. For example,* ***routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure****."* No separate payment is recommended.

- Revenue Code 278 includes Procedure code C1781 which 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. DWC Rule §133.10 (2)(QQ) states, "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested." Review of the submitted medical bill found no request for separate implant reimbursement was made. No reimbursement recommended.

- Procedure code 80048 has a status indicator of Q4 and is included with payment for the primary procedure.

- Procedure code 85025 has a status indicator of Q4 and is included with payment for the primary procedure.

- Revenue Code 360 - Procedure code 49650-50 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5361. The OPPS Addendum A rate is $5,212.15 multiplied by 60% for an unadjusted labor amount of $3,127.29, in turn multiplied by facility wage index 0.8631 for an adjusted labor amount of $2,699.16.

  The non-labor portion is 40% of the APC rate, or $2,084.86.

  The sum of the labor and non-labor portions is $4,784.02.

  The Medicare facility specific amount is $4,784.02. This is multiplied by 200% for a MAR of $9,568.04.

  The provider billed this code with modifier 50. Bilateral payment adjustment does apply to this code. Per the Medicare bilateral procedure, this allowable is multiplied by 50% (9,568.04 x 50% = $4,784.02) The total MAR is ($9,568.04 + $4,784.02 = $14,352.06).

- Revenue Code 360 - Procedure code 49594 also has a status indicator of J1. Medicare payment policy allows payment for only the highest ranking J1 procedure to be paid.

Review of Addenda J at www.cms.gov found Code 49594 has a ranking of 1,049. Code 49650 has a ranking of 1,031. Payment is allowed only for code 49650.

- Revenue Code 360 – S2900 is not valid for Medicare purposes. DWC Rule §134.403 (d) states in pertinent part, "For coding, billing, reporting and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provide." No payment is recommended.

- Revenue code 370 – Anesthesia. As shown above anesthesia is packaged into the surgical procedure.

- Revenue Code 636 - Procedure code C9290 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.

- Revenue Code 636 - Procedure code J0131 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.

- Revenue Code 636 - Procedure code J0330 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.

- Revenue Code 636 - Procedure code J0690 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.

- Revenue Code 636 - Procedure code J1100 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.

- Revenue Code 636 - Procedure code J1170 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.

- Revenue Code 636 - Procedure code J2175 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.

- Revenue Code 636 - Procedure code J2250 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.

- Revenue Code 636 - Procedure code J2405 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.

- Revenue Code 636 - Procedure code J2704 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.
- Revenue Code 636 - Procedure code J2710 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.
- Revenue Code 636 - Procedure code J3010 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.
- Revenue Code 636 - Procedure code J7120 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.
- Revenue code 710 – Recovery room services is packaged into surgical procedure.
- Procedure code 93005 has status indicator Q1, for STV-packaged codes; reimbursement is packaged into primary J1 procedure. No separate reimbursement recommended.

2. The total recommended reimbursement for the disputed services is $14,352.06. The insurance carrier paid $9,458.60. The amount due is $4,893.46. 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 Phoenix Insurance Co must remit to Northeast Baptist Hospital $4,893.46 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 30, 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.