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
Bitco General Insurance Corp

MFDR Tracking Number
M4-24-1958-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 8, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 20, 2023	250	$83.80	$0.00
July 20, 2023	250	$40.20	$0.00
July 20, 2023	258	$17.65	$0.00
July 20, 2023	270	$1404.00	$0.00
July 20, 2023	272	$1506.00	$0.00
July 20, 2023	278	$5151.00	$0.00
July 20, 2023	278	$592.00	$0.00
July 20, 2023	278	$592.00	$0.00
July 20, 2023	278	$560.00	$0.00
July 20, 2023	278	$474.00	$0.00
July 20, 2023	278	$197.00	$0.00
July 20, 2023	278	$182.00	$0.00
July 20, 2023	278	$150.00	$0.00
July 20, 2023	80048 QW	$595.00	$0.00
July 20, 2023	87081	$416.00	$0.00
July 20, 2023	85027	$361.00	$0.00
July 20, 2023	81003	$222.00	$0.00
July 20, 2023	36415	$95.00	$0.00
July 20, 2023	25210 LT	$9545.00	$1,915.43
July 20, 2023	25210 LT	$3181.67	$2,686.44

July 20, 2023	64772 LT	$3181.67	$0.00
July 20, 2023	20680 LT	$3181.66	$0.00
July 20, 2023	370	$14012.00	$0.00
July 20, 2023	710	$1345.00	$0.00
July 20, 2023	G0463 25	$1336.00	$0.00
	Total	$48,421.65	$4,601.87

Requestor's Position

"It is the Hospital's position that (1) the Hospital's bill (including implant invoices) was received by CorVel on October 5, 2023 and October 17, 2023 which is timely under the 95-day deadline for workers' compensation bill submissions; (2) the Hospital never received the CorVel notification letters indicating the bills were being returned; and (3) the reasons for denying the Hospital's bill are internal computer system issues create by CorVel. It is through no fault of the Hospital that the CorVel internal computer claim system cannot calculated negative charges on a bill. The bills were timely received within 95 days of date of service, should not have been returned as incomplete, but rather processed for review and reimbursement."

Supplemental response July 2, 2024

"The total billed amount was $48,421,65. Requestor Texas Spine & Joint Hospital received a partial payment of $3,761.75 and did not receive any payment for implant reimbursement as allowed for under the workers' compensation rules. The implant invoices were included in my request for medical dispute resolution and the Requestor still seeks reimbursement for implant reimbursement. Therefore, Requestor is continuing with dispute resolution."

Amount in Dispute: $48,421.65

Respondent's Position

"It is unclear why the bill was returned to the provider for the reason given. However, this disservice has been rectified and payment has been made -including interest. Please see attached EOR showing payment recommendation. Check/EFT info is below. There was no willful intent to deprive the HCP of payment for services rendered."

Response submitted by: CorVel

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 §133.10 sets out requirements of institutional billing when requesting separate payment of implants.

3. 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.

- 234 – This procedure is not paid separately.
- 45 – Contract/legislated fee arrangement exceeded.
- RN – Not paid under OPPS; services included in APC rate.
- P14 – Payment is included in another svc/procedure occurring non same day.
- 25 – Separate E&M Service, same physician.
- 97 – Charge included in another charge or service.
- RZ0 – Status indicator: Q4 packaged lab service.
- W3 – Appeal/reconsideration.
- R09 – CCI; CPT Manual and CMS coding manual instructions.
- RZ0 – Status indicator: Q4 packaged lab service.
- 29 – Time limit for filing claim/bill has expired.
- RD7 – Multiple procedure/1st procedure.
- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers' compensation state regulations/fee schedule requirements.

Issues

1. Is the insurance carrier's reduction in payment supported?
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 July of 2023. The insurance carrier made a payment of $3,761.75 on May 28, 2024 via check number 1270691. Review of the explanation of review submitted with this payment indicates reductions based on packaging and status indicator. Application of the applicable fee guideline is shown 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.

   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.

   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 250 (Pharmacy). The Medicare payment policy applicable to this revenue code is found at www.cms.gov, Claims Processing Manual, Chapter 10.4 – Packaging, *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,***

- Revenue code 250 (Pharmacy). Packaged into primary procedure.
- Revenue code 258(IV Solutions). Packaged into primary procedure.
- Revenue code 270(Supplies). Packaged into primary procedure.
- Revenue code 272(Supplies). Packaged into primary procedure.
- Procedure code C1713 – DWC Rule 28 TAC 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 (UB-04) found no request for separate reimbursement of implants was indicated in box 80. No separate reimbursement is recommended.
- Procedure code C1713 as above.
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- Procedure code 80048 QW, for date of service July 13, 2023 has a status indicator of Q4 and is packaged into J1 procedure.
- Procedure code 87081, for date of service July 13, 2023 has a status indicator of Q4 and is packaged into J1 procedure.
- Procedure code 85027, for date of service July 13, 2023 has a status indicator of Q4 and is packaged into J1 procedure.
- Procedure code 81003 QW, for date of service July 13, 2023 has a status indicator of Q4 and is packaged into J1 procedure.
- Procedure code 36415, for date of service July 13, 2023 has a status indicator of Q4 and is packaged into J1 procedure.
- Procedure code 25210 – Carpectomy LT; 1 bone, 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 5113. The OPPS Addendum A rate is $2,976.66. This is multiplied by 60% for an unadjusted labor amount of $1,786.00, in turn multiplied by facility wage index 0.8375 for an adjusted labor amount of $1,495.78. The

non-labor portion is 40% of the APC rate, or $1,190.66. The sum of the labor and non-labor portions is $2,686.44. The Medicare facility specific amount is $2,686.44. This is multiplied by 200% for a MAR of $5,372.88.

- Procedure code 25210 LT. Review of the submitted "Operative Report" indicates, "Lunate and triquetrum were removed under fluoroscopic guidance…" Based on this review a second procedure (removal of bone) was performed. The applicable Medicare payment policy indicates the code 25210 is subjected to multiple procedure discounting. Therefore, the MAR associated with this second procedure is $5,372.88 ÷ 50% = $2,686.44.

- Procedure code 64772 LT has a ranking of J1. The applicable Medicare payment policy allows payment on the highest ranked J1 procedure. Review of the rankings indicated in Addenda J at www.cms.gov indicates code 64772 has a ranking of 2,742. Code 25210 has a ranking of 1,976. Code 25210 is the highest ranked J1 code and receives payment.
- Procedure code 20680 LT has a ranking of Q2 and is packaged into J1 procedure.
- Revenue code 370 (Anesthesia). Packaged into primary procedure.
- Revenue code 710 (Recovery room). Packaged into primary procedure.
- Procedure code G0463 25, for date of service July 13, 2023 would have a J2 status indicator if billed in combination with eight or more hours of observation. As the criteria for comprehensive observation is not met, the associated APC has a status indicator of V. This service is packaged into J1 procedure.

3. The total recommended reimbursement for the disputed services is $8,059.32. The insurance carrier paid $3,457.45. The amount due is $4,297.57. 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 Bitco General Insurance Corp must remit to Texas Spine and Joint Hospital $4,297.57 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	July 26, 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.