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

General Information

Requestor Name
Memorial Hermann Specialty Hospital

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-24-2001-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Findings
February 6, 2024	25607	$6,228.27	$6,228.27

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated May 8, 2024, addressed to Texas Department of Insurance that states, "According to TX Workers Compensation Fee Schedule the expected reimbursement for CPT code 25607 is $13,482.97."

Amount in Dispute: $6,228.27

Respondent's Position

"The provider filed a DWC 60 seeking Medical Fee Dispute Resolution for a date of service of February 6, 2024. It is not clear if the provider is claiming to have submitted a request for reconsideration to the carrier at least 35 days prior to filing its request for Medical Fee Dispute Resolution. The carrier is not aware of the provider filing a request for reconsideration until the one that is in the provider's DWC 60 packet that is dated May 8, 2024. If that is the provider's only request for reconsideration, then the request for Medical Fee Dispute Resolution has been prematurely filed. Specifically, the provider must file a request for reconsideration prior to filing a request for medical fee dispute resolution. See rule 133.250."

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 denied the payment for the disputed services with the following claim adjustment codes:

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' Compensation State Fee Schedule Adj.
- APRV – The Provider's charges were reviewed with consideration of the Payer's UR/Preauthorization Decision(s) governing this Claimant.
- CBRH – Complex Hospital / ASC bill review.
- J8 – The allowance for the device intensive procedure was paid at an adjusted rate.
- PN - The service is considered incidental, packaged, or bundled into another service or APC payment.
- PS – The charge exceeds the APC rate for this service.
- @G(W3) – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

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

Findings

1. The respondents states in their position statement, "…The carrier is not aware of the provider filing a request for reconsideration until the one that is in the provider's DWC 60 packet that is dated May 8, 2024…"

   Review of the submitted documentation finds an explanation of benefits titled "Reconsideration" dated March 31, 2024. Based on these finds, the respondent's position is

not supported.

2. The requestor is seeking additional payment of outpatient hospital services rendered in February of 2024. The insurance carrier reduced the charges based on workers' compensation state fee schedule and packaging. The calculation of maximum allowable reimbursement per applicable fee guideline is shown below.

   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.

   - Procedure code 25607 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 5114. The OPPS Addendum A rate is $6,816.33 multiplied by 60% for an unadjusted labor amount of $4,089.80, in turn multiplied by facility wage index 0.9817 for an adjusted labor amount of $4,014.96.

The non-labor portion is 40% of the APC rate, or $2,726.53.

The sum of the labor and non-labor portions is $6,741.49.

The Medicare facility specific amount is $6,741.49 multiplied by 200% for a MAR of $13,482.98.

3. The total recommended reimbursement for the disputed services is $13,482.98. The insurance carrier paid $7,254.70. The requestor is seeking additional reimbursement of $6,228.27. 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 Zurich American Insurance Co must remit to Memorial Hermann Specialty Hospital $6,228.27 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	June 17, 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.