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
Providence Sierra

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-24-2614-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
July 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 28 – 31, 2023	0250	$311.00	$0.00
	0278	$110097.18	$0.00
	0300	$4314.00	$0.00
	0320	$137.51	$0.00
	0360	$88647.39	$0.00
	0370	$12266.00	$0.00
	0636	$3101.00	$0.00
	0710	$9178.00	$0.00
	0730	$748.48	$0.00
	WC ADJUSTMENTS	-222114.16	$0.00
	Total	$7,766.40	$0.00

Requestor's Position

"The Hospital provided the medically necessary services on the above dates of service. The Hospital billed CHUBB, but the bill was underpaid and not paid in reimbursed appropriately in accordance with Chapter 134 for Revenue Code 278. However, despite the Hospital's efforts and Request for Reconsideration to CHUBB on November 14, 2023, and July 2, 2024, CHUBB has not rendered proper payment."

Amount in Dispute: $7,766.40

Respondent's Position

"The Respondent performed a preliminary reconsideration with the intent of paying the bill per rule 134.403. However, in doing so it was determined that the HCP owes a refund to the Carrier in the amount of $1148.26).

- The Speedbridge system and Swivelock anchors were reimbursed as they were documented in the Op Report. Speedbridge system $1914 + 10% = $2105.40 / Swivelock anchors $495 x 2 =$990 + 10% = $1089. TOTAL REIMBURSEMENT – $3194.40
- The human tissue/paste invoice was **NOT** reimbursed as there is no indication this was implanted. The OP report was reviewed by a surgical nurse who also did not see the use of the human tissue/paste.
- The surgical procedure code's (29827) reimbursement dropped from $12,142.61 to **$7892.70** due to the request for separate implant reimbursement.

Combining all three bullet points above, no additional payment is due – but rather an overpayment now exits."

Response submitted by: CorVel Healthcare Corporation

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 reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 234 – This procedure is not paid separately.
- 97 – Charge included in another Charge or Service.
- RN - not paid under OPPS: services included in APC rate.
- RZ0 – Status Indicator: Q4 Packaged Lab service
- XP – Separate Practitioner
- P14 – Payment is included in another svc/procedure occurring on same day
- 59 – Allowance based on Multiple Surgery Guidelines.

- P12 – Workers' compensation State Fee Schedule Adj
- B12 – Svcs not documented in patient medical records
- IMP – Implant/DME allowance
- W3 – 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 payment of outpatient hospital services rendered in August of 2023. The insurance carrier reduced the payment based on workers' compensation fee schedule. The maximum allowable reimbursement (MAR) is calculated as follows.

   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 respondent allowed the requestor to seek separate implant reimbursement at the time of reconsideration. The Medicare facility specific reimbursement amount will 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 services. CMS Internet Only Manual Chapter 4 Section 10.4 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 or the surgical procedure.*" Packaged no separate payment

- Revenue Code 278 – Implants. Review of the submitted medical bill found the following items.

    - SYS SPEEDBRDIGE" as identified in the itemized statement with a cost per unit of $1,914.00;

    - "ANCH SWIVELOCK" as identified in the itemized statement with a cost per unit of $495.00 at 2 units, for a total cost of $990.00;

    - "TISS CONN HUMAN PASTE" as identified in the itemized statement with a cost per unit of $4,995.00 however, the use of this item as in implant was not supported by the operative report. No reimbursement is recommended.

    - The total net invoice amount (exclusive of rebates and discounts) is $2,904.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $290.40. The total recommended reimbursement amount for the implantable items is $3,194.40.

- Revenue code 300 – Laboratory Charges. These codes have a status indicator of Q4 and are packed into primary procedure.

- Revenue Code 320 – X-ray. Procedure code 71046 has a status indicator of Q1 and is packaged into primary procedure.

- Revenue Code 360 – Represents operating room services billed under the following HCPCS codes.

    - Procedure code 29827 has a status indicator of J1 as does code 29823. The applicable Medicare payment policy allows for only the highest ranking J1 code to receive payment. Review of the applicable addenda J at www.cms.gov finds code 29827 has a ranking of 485. Code 29823 has a ranking of 1,776. Therefore, only code 29827 will receive payment.

      The APC associated with 29827 is 5114 with a payment rate of $6,614.63 multiplied by 60% is $3,967.78 multiplied by facility wage index of 0.8631 equals the labor adjustment amount of $3,425.45.

The non labor rate is $2,645.85.

Total Medicare facility specific allowable $6,071.30 multiplied by 130% equals Medicare Facility specific allowable of $7,892.69.

- Procedure code 29825 has a status indicator of N. No separate payment is allowed.
- Procedure Code 64415 has a status indicator of T and is packaged into primary J1 procedure.

- Revenue Code 370 – Anesthesia is packaged as integral part of surgical procedure.
- Revenue Code 0636- Drugs. Status indicator of N. Packaged into surgical procedure.
- Revenue Code 0710 – Recovery room. Packaged as integral part of surgical procedure.
- Revenue Code 0730 – EKG/ECG code 93005 has status indicator of Q1 and is packaged into primary procedure.

2. The total recommended reimbursement for the disputed services is $11,087.09. The insurance carrier paid $12,407.62. Additional payment is not 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		September 5, 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.