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
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
TEXAS WATER CONSERVATION ASSOC

MFDR Tracking Number
M4-21-2133-01

Carrier's Austin Representative
Box Number 43

DWC Date Received
July 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 24, 2021 to March 25, 2021	Outpatient Hospital Service	$4,379.46	$87.96
	Total	$4,379.46	$87.96

Requestor's Position

"After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 25609, allowed amount of $5,675.92, multiplied at 200%, CPT Code 25652, allowed amount of $5675.92, multiplied at 200% x 5 and CPT Code 96374, allowed amount of $184.37, multiplied at 200% reimbursement should be $17,396.50. Payment received was only $11,263.88, thus, according to these calculations; there is a pending payment in the amount of $4,379.46."

Amount in Dispute: $4,379.46

Respondent's Position

"With further review no additional payment appears to be owe to the provider as prior payment was made accordingly per rule 134.403 OPPS hospital outpatient payment system of the APC rate at 200% as the provider id not request separate reimbursement implants."

Response Submitted by: Sedgwick

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 18 – Exact duplicate claim/service

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall

be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code A6222 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 C1713 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 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 80048 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 82962 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 85027 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 0241U has status indicator A, for services paid by fee schedule or payment system other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the code on the date provided. Per DWC Professional Fee Guideline, Rule §134.203(e)(1), the facility fee is based on Medicare's Clinical Laboratory fee for this code of $0.00. 125% of this amount is $0.00
   - Procedure code 25609 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 $6,264.95. This is multiplied by 60% for an unadjusted labor amount of $3,758.97, in turn multiplied by facility wage index 0.8433 for an adjusted labor amount of $3,169.94. The non-labor portion is 40% of the APC rate, or $2,505.98. The sum of the labor and non-labor portions is $5,675.92. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the cost of a service exceeds both 1.75 times the OPPS payment and also

the fixed-dollar threshold of $5,075, the outlier payment is 50% of the amount in excess of 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.136. This ratio is multiplied by the billed charge of $14,168.78 for a cost of $1,926.95. The cost of packaged items is allocated proportionately across all separately paid OPPS services based on percentage of the total APC payment. The APC payment of $5,675.92 divided by the sum of APC payments is 100.00%. The sum of packaged costs is $3,236.80. The allocated portion of packaged costs is $3,236.80, which is added to the service cost for a total cost of $5,163.75. The cost of services exceeds the fixed-dollar threshold of $5,075. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The Medicare facility specific amount is $5,675.92. This is multiplied by 200% for a MAR of $11,351.84.

- Per Medicare policy, procedure code 25652 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 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- Procedure code J2370 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 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.
- 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.

- Procedure code J2270 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 A9270 has status indicator E1, for excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Per Medicare policy, procedure code 96374 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.

4. The total recommended reimbursement for the disputed services is $11,351.84. The insurance carrier paid $11,263.88. The amount due is $87.96. 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 of $87.96 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 Texas Water Conservation Assoc must remit to Doctors Hospital at Renaissance $87.96 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted]

[redacted]
Medical Fee Dispute Resolution Officer

September 30, 2021
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.