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**
Gray Insurance Co Inc

**MFDR Tracking Number**
M4-21-2409-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
August 24, 2021

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| June 10, 2021 | 29888 | $4,134.99 | $2,878.45 |
| | **Total** | $4,134.99 | $2,878.45 |

## Requestor's Position

According to TWCC guidelines, Rule §134.403 states that reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount.

**Amount in Dispute:** $4,134.99

## Respondent's Position

Between the two EOBs, the recommendation was the reimbursement of $8,463.39. The provider is not entitled to any additional reimbursement.

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

2. 28 TAC §134.403 sets out the fee guidelines for [description].

Denial Reasons

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

- 797 – Service not paid under Medicare OPPS
- 877 – Reimbursement is based on the contracted amount
- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 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 indication determines the service is packaged or excluded from payment

Issues

1. Is the insurance carriers' denial supported?

2. What rule applies for determining reimbursement for the disputed services?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for services rendered in an outpatient hospital setting on June 10, 2021, in the amount of $4,134.99. The insurance company reduced the disputed service based on contract with PHS (PMCS). Insufficient evidence was found to support the injured worker was enrolled in this certified network. The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

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).

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 medical bill did not contain a request for separate reimbursement of implants. The Medicare facility amount will be multiplied by 200%.

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 29888 has status indicator J1, 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.

  The Medicare facility specific amount is $5,675.92 multiplied by 200% for a MAR of $11,351.84.

3. The total recommended reimbursement for the disputed services is $11,351.84. The insurance carrier paid $8,473.39. The amount due is $2,878.45. 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 $2,878.45 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 Gray Insurance Co Inc must remit to Doctors Hospital at Renaissance $2,878.45 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | |
|---|---|---|
| | | September 24, 2021 |
| 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.