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

General Information

Requestor Name
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
XI insurance America Inc.

MFDR Tracking Number
M4-22-0017-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 7, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 5, 2021 and May 6, 2021	Outpatient Facility Charges	$5,954.04	$39.74
	Total	$5,954.04	$39.74

Requestor's Position

"According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount…. Based on CPT Code 76000, allowed amount of $208.49 multiplied at 200%, CPT Code 26565, allowed amount of $2,564.29 multiplied at 200%, CPT Code 26615, allowed amount of $2,564.29 multiplied at 200%, CPT Code 96374, allowed amount of $184.37 multiplied at 200%, reimbursement should be $11,042.88. Payment received was only $5,088.84 thus, according to these calculations; there is a pending payment in the amount of $5,954.04."

Amount in Dispute: $5,954.04

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett

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 reimbursement guidelines for outpatient hospital services.

Denial Reasons

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

- 96 – Non-covered charges
- B20 – Payment adjusted because procedure/service was partially or fully furnished by another provider
- P12 – Workers Compensation jurisdictional fee scheduled adjustment
- 00663 - REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE FEE SCHEDULE GUIDELINES
- 4097 - PAID PER FEE SCHEDULE; CHARGE ADJUSTED BECAUSE STATUTE DICTATES ALLOWANCE IS GREATER THAN PROVIDER'S CHARGE.
- 6183 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
- 797 - SERVICE NOT PAID UNDER MEDICARE OPPS.
- 802-1 - CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
- 90136 - NON-COVERED CHARGE(S).
- 90223 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 90381 - PAYMENT ADJUSTED BECAUSE PROCEDURE/SERVICE WAS PARTIALLY OR FULLY FURNISHED BY ANOTHER PROVIDER.
- 96 - NON-COVERED CHARGE(S).
- 97-1 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENTIALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- B20 - PAYMENT ADJUSTED BECAUSE PROCEDURE/SERVICE WAS PARTIALLY OR FULLY FURNISHED BY ANOTHER PROVIDER.
- P12-1 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 93 - No Claim level Adjustments.

Issue(s)

Is the insurance carriers' denial supported?

Findings

The requestor seeks additional reimbursement in the amount of $5,954.04 for outpatient hospital services rendered on May 5, 2021 and May 6, 2021. The insurance carrier reduced the disputed services based on fee schedule adjustment.

DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement shall 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 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 26565 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 $2,830.40. This is multiplied by 60% for an unadjusted labor amount of $1,698.24, in turn multiplied by facility wage index 0.8433 for an adjusted labor amount of $1,432.13. The non-labor portion is 40% of the APC rate, or $1,132.16. The sum of the labor and non-labor portions is $2,564.29. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $2,564.29. This is multiplied by 200% for a MAR of $5,128.58. The carrier paid $5,088.84; therefore, the requestor is entitled to an additional reimbursement in the amount of $39.74.
- Per Medicare policy, procedure code 26615 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.
- Per Medicare policy, procedure code 76000 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.
- 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.

The DWC finds that the requestor is therefore entitled to an additional payment in the amount of $39.74, therefore 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 $39.74 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 the Respondent must remit to Requestor $39.74 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 1, 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.