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
Great Midwest Insurance Co

MFDR Tracking Number
M4-22-0203-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 1, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 11, 2021	86850	90.16	$0.00
May 11, 2021	86900	202.84	$0.00
May 11, 2021	86901	61.32	$0.00
May 11, 2021	88304	90.16	$0.00
May 11, 2021	72020	146.58	$0.00
May 11, 2021	63030	11351.84	$0.00
May 11, 2021	96374	368.74	$0.00
	Total	$12,311.64	$0.00

Requestor's Position

Requestor did not submit a position statement but did submit a copy of their reconsideration that states, "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. After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $12,311.64

Respondent's Position

The Request for Reconsideration declares entitlement to payment and calculates a claimed amount due for 63030, but does not explain or document why it is so entitled.

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 outpatient hospital services.

Denial Reasons

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

- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment
- 797 – Service not paid under Medicare OPPS
- 886 – The procedure was inappropriately billed. The provider has previously billed for an initial/evaluation
- 906 – In accordance with clinical based coding edits (National Correct Coding initiative/outpatient code editor
- TX97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another
- TXB16 – Payment adjusted because new patient qualifications were not met
- TXP12 – Workers compensation jurisdictional fee schedule adjustment

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered in May 2021. The insurance carrier reduced the charges based on the workers' compensation fee schedule, bundling and NCCI edits.

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).

Review of the submitted medical bill and the applicable fee Medicare payment policy is shown below.

- Procedure code 86580 is packaged into Code 63047 the highest ranking J1 code. No additional payment is recommended.
- Procedure code 86900 is packaged into Code 63047 the highest ranking J1 code. No additional payment is recommended.
- Procedure code 86901 is packaged into Code 63047 the highest ranking J1 code. No additional payment is recommended.
- Procedure code 88304 is packaged into Code 63047 the highest ranking J1 code. No additional payment is recommended.
- Procedure code 72020 is packaged into Code 63047 the highest ranking J1 code. No addition payment is recommended.
- Procedure code 63030 has a status indicator of J1. The Medicare Claims Processing Manual at www.cms.gov states, *When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service.*"

  Review of Addenda J found the ranking of code 63030 is 725. The ranking of the code 63047 which is also a J1 code is 686. Code 63047 is the highest ranking J1 code and receives reimbursement. No additional payment is recommended.

2. No additional reimbursement is recommended for the services in dispute listed on the DWC060.

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 not entitled to additional reimbursement for the disputed services.

Authorized Signature

		November 2, 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.