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

General Information

Requestor Name
Christus Santa Rosa Healthcare

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-22-0386-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
October 25, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 4, 2021	27792	$3,771.60	$0,00
	Total	$3,771.60	$0,00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "In accordance with the TX WC fee schedule the code is surgical and should be paid @GARR: $6016.48 *200%."

Amount in Dispute: $3,771.60

Respondent's Position

We are in receipt of the above captioned medical fee dispute resolution. Payment of $4191.08 has been made.

Response submitted by: Broadspire

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:

- 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas Markup
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 885 – Review of this code has resulted in an adjusted reimbursement
- P12 – 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. 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 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 27792 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 multiplied by 60% for an unadjusted labor amount of $3,758.97, in turn multiplied by facility wage index 0.9339 for an adjusted labor amount of $3,510.50.

  The non-labor portion is 40% of the APC rate, or $2,505.98.

  The sum of the labor and non-labor portions is $6,016.48.

  The Medicare facility specific amount is $6,016.48 multiplied by 200% for a MAR of $12,032.96.

2. The total recommended reimbursement for the disputed services is $12,032.96. The insurance carrier paid $12,527.44. 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 not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 29, 2022 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.