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
AIU INSURANCE CO

MFDR Tracking Number
M4-22-0387-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 23, 2021 to August 24, 2021	Hospital Outpatient Service	$1,701.32	$254.44
	Total	$1,701.32	$254.44

Requestor's Position

"After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 11760, allowed amount of $237.45, multiplied at 200%, CPT Code 26765, allowed amount of $2,564.29, multiplied at 200%, CPT Code 11010, allowed amount of $281.75, multiplied at 200% and CPT Code 96374, allowed amount of $184.37, multiplied at 200% reimbursement should be $6,535.72. Payment received was only $4,834.40, thus, according to these calculations; there is a pending payment in the amount of $1,701.32."

Amount in Dispute: $1,701.32

Respondent's Position

"The provider filed a DWC-60 seeking medical fee dispute resolution for service dates of August 23, 2021 and August 24, 2021. We are attaching a copy of the provider's UB-04s as well as EOR's

dated September 13, 2021 and October 13, 2021. As noted on the providers' DWC-60, the carrier has already reimbursed the provider in the amount of $4,834.40. The provider is seeking additional reimbursement of $1,701.32."

Response Submitted by: Flahie, 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 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:

- 2005 – No additional reimbursement allowed after review of appeal/reconsideration
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- P12 – Workers Compensation Jurisdictional Fee Schedule adjustment
- W3 – Bill is a reconsideration or appeal

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 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.

2. 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, billed August 23, 2021, 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, billed August 23, 2021, 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 0202U, billed August 23, 2021, 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 80048, billed August 23, 2021, 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.
    - Per Medicare policy, procedure code 11760 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 26765 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 0.8316 for an adjusted labor amount of $1,412.26. The non-labor portion is 40% of the APC rate, or $1,132.16. The sum of the labor and non-labor portions is $2,544.42. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $2,544.42. This is multiplied by 200% for a MAR of $5,088.84.

- Per Medicare policy, procedure code 11010 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 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 J1885 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 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 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 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 J1580 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 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 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.

3. The total recommended reimbursement for the disputed services is $5,088.84. The insurance carrier paid $4,834.40. The amount due is $254.44. 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 $254.44 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 AIU INSURANCE must remit to DOCTORS HOSPITAL AT RENAISSANCE $254.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted] S[redacted]

Signature | Medical Fee Dispute Resolution Officer | June 7, 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.