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**
ZURICH AMERICAN INSURANCE COMPANY

**MFDR Tracking Number**
M4-22-1459-01

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

**DWC Date Received**
March 16, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| September 21, 2021 and September 23, 2021 | Outpatient Facility Charges | $3,471.26 | $0.00 |
| | **Total** | $3,471.26 | $0.00 |

## Requestor's Position

"After reviewing the account, we have concluded that reimbursement received was inaccurate. Based on CPT Code 11760, allowed amount of $2,371.15, multiplied at 200%, CPT Code 26765, allowed amount of $2,564.29, multiplied at 200%, CPT Code 11012, allowed amount of $1,073.59, multiplied at 200%, CPT Code 94640, allowed amount of $170.22, multiplied at 200%, CPT Code 93005, allowed amount of $50.43, multiplied at 200% and CPT Code 96374, allowed amount of $184.37, multiplied at 200% reimbursement should be $8,560.10. Payment received was only $5,088.84, thus, according to these calculations; there is a pending payment in the amount of $3,471.26."

**Amount in Dispute:** $3,471.26

## Respondent's Position

"We are attaching a copy of the carrier's EORs dated October 29, 2021 and February 21, 2022… It is the carrier's position based upon the EORs dated October 29, 2021 and February 21, 2022 that the provider is entitled to total reimbursement of $5,088.84. The provider is not entitled to additional reimbursement."

**Response Submitted by:** Flahive, Ogden & Latson

# Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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 outpatient hospital facility fee guidelines.

Denial Reasons

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

- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- 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 indicator determines the service is packaged or excluded from payment.
- 797 – SERVICE NOT PAID UNDER MEDICARE OPPS.
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
- 906 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING. INITIATIVE/OUTPATIENT CODE EDITOR). COMPONENT CODE OF COMPREHENSIVE MEDICINE, EVALUATION AND MANAGEMENT SERVICES PROCEDURE (90000-99999) HAS BEEN DISALLOWED.
- 96 – NON-COVERED CHARGE(S).
- 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- N569 – Not covered when performed for the reported diagnosis.
- N702 – Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.

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 seeks additional reimbursement for outpatient facility charges rendered on September 21, 2021 and September 23, 2021. The insurance carrier issued a payment and reduced the remaining charges with denial reason codes indicated above. The Requestor states, "Payment received was only $5,088.84, thus, according to these calculations; there is a pending payment in the amount of $3,471.26."

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 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 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.

3. The total recommended reimbursement for the disputed services is $5,088.84. The insurance carrier paid $5,088.84. 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.

The DWC finds the requester has established that additional reimbursement of $0.00 is due.

## Order

Under TLC §§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 | June 7, 2022<br>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.