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
METSL LLC

Respondent Name
Massachusetts Bay Insurance Co

MFDR Tracking Number
M4-22-1647-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
April 5, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 22, 2021	27828	$11,799.25	$10.35
	Total	$11,799.25	$10.35

Requestor's Position

The requestor did not submit a position statement with their request for medical fee dispute resolution but did submit a copy of their reconsideration that states, "Outpatient services should be reimbursed at 200% of Medicare APC Rate."

Amount in Dispute: $11,799.25

Respondent's Position

"After careful re-review of the submitted documentation it has been determined that an additional allowance is owed. The bill was reprocessed on 4/19/2022 to allow an additional allowance of $11,788.90."

Response submitted by: Medata Service Operations

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:

- W3 – Additional payment made on appeal/reconsideration
- 97 – The service is considered incidental, packaged, or bundled into another service or APC payment
- P12 – Your billing has been paid in accordance with the Inpatient Hospital Fee Schedule or the Outpatient Fee Schedule

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 payment for outpatient hospital services rendered in April 2021. The insurance carrier made an original payment of $12,208.13 and at reconsideration an additional payment of $11,788.90 was made. The total payment amount was $23,997.03.

   The requestor asked to continue with medical fee dispute resolution.

   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).

   DWC Rule 28 TAC 134.403 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable

outlier payment amounts and reimbursement for implatables.

DWC Rule 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 27828 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 5115 with the OPPS Addendum A rate of $12,314.76 multiplied by 60% for an unadjusted labor amount of $7,388.86, in turn multiplied by facility wage index 0.9579 for an adjusted labor amount of $7,077.79.
  The non-labor portion is 40% of the APC rate, or $4,925.90.
  The sum of the labor and non-labor portions is $12,003.69. The Medicare facility specific amount is $12,003.69. This is multiplied by 200% for a MAR of $24,007.38.

2. The total recommended reimbursement for the disputed services is $24,007.38. The insurance carrier paid $23,997.03. The amount due is $10.35. 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 $10.35 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 respondent must remit to requestor $10.35 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 15, 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.