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
Tx Municipal League Intergovernmental Risk

MFDR Tracking Number
M4-22-1816-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 1, 2022	N4	$0.00	$0.00
February 1, 2022	An airway LMA	$0.00	$0.00
February 1, 2022	Dressing ABD Pad 8" x 10"	$0.00	$0.00
February 1, 2022	L1830	$0.00	$0.00
February 1, 2022	C1713	$0.00	$0.00
January 27, 2022	36415	$0.00	$0.00
January 27, 2022	80051	$0.00	$0.00
January 27, 2022	85027	$0.00	$0.00
January 27, 2022	87635	$0.00	$0.00
February 1, 2022	29888	$0.00	$0.00
February 1, 2022	29883	$2,588.42	$0.00
February 1, 2022	Anesthesia Gen Level	$0.00	$0.00
February 1, 2022	Recovery Room 1st Hour	$0.00	$0.00
February 1, 2022	96374	$373.96	$0.00

Requestor's Position

"The requestor did not submit a position statement but did submit a copy of their reconsideration that states in pertinent part, "After reviewing the account we have concluded that reimbursemen received was inaccurate. Based on CPT Code 2988, allowed amount of $5,724.98 multiplied at 200%, CPT Code 29883 allowed amount of $1,294.21, multiplied at 200% and CPT cod 96374, allowed amount of $186.98, multiplied at 200% reimbursement should be $14,41`2.34."

Amount in Dispute: $2,962.38

Respondent's Position

Response submitted by: "The Provider has already been paid under the primary "J1" service such that no additional reimbursement is owed."

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:

- P12 – Workers' Compensation Jurisdictional fee schedule
- 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas markup
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline
- 282 – Denial after reconsideration no additional payment due

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestotr is seeking additional reimbursement for outpatient hospital services rendered in January/February 2022. The insurance carrier reducaed the allowed amount based on tworkers' compensation fee guideline.

   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 (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 29888 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 $6,397.05 multiplied by 60% for an unadjusted labor amount of $3,838.23, in turn multiplied by facility wage index 0.8249 for an adjusted labor amount of $3,166.16.

     The non-labor portion is 40% of the APC rate, or $2,558.82.

     The sum of the labor and non-labor portions is $5,724.98.

     The Medicare facility specific amount is $5,724.98. This is multiplied by 200% for a MAR of $11,449.96.

   - Procudure code 29883 has a status indicator J1. The CMS Medicare claims processing manual states in pertinent part, "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. Procedure code 29888 has a ranking of 384. Procedure code 29883 has a ranking of 1,326. Only the highest ranking (Code 29888) is eligible for payment. No payment is recommended for Code 29883.

- Procedure code 96374 has a status indicator of S and is bundled into primary procedure 29888. No payment is recommended.

2. The total recommended reimbursement for the disputed services is $11,449.96. The insurance carrier paid $11,680.01. 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

		May 26, 2022
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.