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
TEXAS COTTON GINNERS TRUST

MFDR Tracking Number
M4-22-2313-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
June 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 10, 2022	Outpatient Facility Charges	$5,182.92	$0.00
	Total	$5,182.92	$0.00

Requestor's Position

"After reviewing the account, we have concluded that reimbursement received was inaccurate. Based on CPT Code 26755, allowed amount of $2,588.42, multiplied at 200%, CPT Code 11012, allowed amount of $2167.14 x 2, multiplied at 200%, CPT Code 11760, allowed amount of $478.69 x 2, multiplied at 200%, CPT Code 26756, allowed amount of $2588.42 x 2, multiplied at 200% and CPT Code 96374, allowed amount $186.98, multiplied at 200% reimbursement should be $16,019.30. Payment received $10,836.38 thus, according to these calculations; there is a pending payment in the amount of $5,182.92."

Amount in Dispute: $5,182.92

Respondent's Position

"Carrier submitted payment commensurate with amounts established by the appropriate Medical Fee Guideline in this matter. Per her email, attached… medical benefits in this matter were actually overpaid. The amounts that were paid were paid according to the appropriate Guide amounts. Additionally, TCGT's UR did not receive a re-submission on this matter from the provider."

Response Submitted by: Paul Kelley Law, PLLC

Findings and Decision

Authority

This Medical Fee Dispute (MFD) 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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §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:

- 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PYMT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- P14 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PYMT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN PERFORMED ON SAME DAY.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

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. The requestor seeks additional payment for outpatient hospital facility services with reimbursement subject to the provisions of 28 TAC §134.403.

   Rule §134.403 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.

   Based on the submitted medical bill, per 28 TAC §134.403(f)(1), the MAR is calculated by multiplying the sum of the Medicare facility specific amount and any applicable outlier payment by 200 percent.

2. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate and hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov. The reimbursement for the services in dispute 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 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 0202U 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 $416.78. 125% of this amount is $520.98. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $472.77. The lesser amount is $472.77.
    - Procedure code 82962 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 26765 may not be reported with another code billed on this same claim. Reimbursement for this is included with payment for the primary procedure. A modifier may be used to differentiate the services. Separate payment is allowed if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed.
    - 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 $2,892.28. This is multiplied by 60% for an unadjusted labor amount of $1,735.37, in turn multiplied by facility wage index 0.8249 for an adjusted labor amount of $1,431.51. The non-labor portion is 40% of the APC rate, or $1,156.91. The sum of the labor and non-labor portions is $2,588.42. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $2,588.42. This is multiplied by 200% for a MAR of $5,176.84.
    - Per Medicare policy, procedure code 26765 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.

- 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.
- 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.
- Per Medicare policy, procedure code 11012 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.
- Per Medicare policy, procedure code 11012 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 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 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 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 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 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 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 $5,649.61. The insurance carrier paid $10,836.43. Additional payment is not recommended.

Conclusion

The outcome of this MFD 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 is not due.

Order

Under TLC §§413.031 and 413.019, the DWC has determined the requestor is not entitled to additional reimbursement for the disputed services

Authorized Signature

_____	_____	September 15, 2022
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this MFD 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 MFD Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. The DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to the 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 MFD 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 the DWC. **Please include a copy of the *MFD 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.