

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-22-2415-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 14, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 1, 2022	N417478082301ML	\$0.00	\$0.00
March 1, 2022	An Airway LMA Unique	\$0.00	\$0.00
March 1, 2022	Dressing ABD pad 8 x 10	\$0.00	\$0.00
March 1, 2022	C1713	\$0.00	\$0.00
February 28, 2022	36415	\$0.00	\$0.00
February 28, 2022	0202u	\$0.00	\$0.00
February 28, 2022	80051	\$0.00	\$0.00
February 28, 2022	85027	\$0.00	\$0.00
March 1, 2022	20900	\$0.00	\$0.00
March 1, 2022	29881	\$2,588.42	\$0.00
March 1, 2022	20680	\$2,167.14	\$0.00
March 1, 2022	Anesthesia	\$0.00	\$0.00
March 1, 2022	J3010	\$0.00	\$0.00
March 1, 2022	J1100	\$0.00	\$0.00
March 1, 2022	J0690	\$0.00	\$0.00
March 1, 2022	J1885	\$0.00	\$0.00
March 1, 2022	J2250	\$0.00	\$0.00
March 1, 2022	J2405	\$0.00	\$0.00
March 1, 2022	A9270	\$0.00	\$0.00

March 1, 2022	Recovery ROOM 1 ST hour	\$0.00	\$0.00
March 1, 2022	96374	\$373.96	\$0.00
	Total	\$5,129.52	\$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 29881, allowed amount of \$1,294.21, multiplied at 200%, CPT Code 20680, allowed amount of \$1083.57, multiplied at 200%. CPT Code 96374, allowed amount of \$186.98, multiplied at 200% reimbursement should be \$16,579.48. Payment received was only \$11,449.96, thus, according to these calculations; there is a pending payment in the amount of \$5,129.52."

Amount in Dispute: \$5,129.52

Respondent's Position

"It remains the carrier's position that it has already reimbursed the provider the total amount the provider is entitled to which is \$11,499.96."

Response submitted by: Flahive, 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 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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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 reimbursement for outpatient hospital services rendered in February and March 2022. The respondent states the requestor has been paid at the correct rate. The maximum allowable reimbursement amount will be calculated per the applicable DWC fee guideline shown below.

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 implantable.

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 C1713 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code 36415, billed February 28, 2022, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 0202U, billed February 28, 2022, is included with payment for the primary procedure.
- Procedure code 80051, billed February 28, 2022, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.

- Procedure code 85027, billed February 28, 2022, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 20900 has status indicator J1 and a ranking of 454 found in Addenda J at www.cms.gov. The Medicare Claims processing manual states in pertinent part, *payment is based on the rate associated with the highest ranking J1 service*. As the highest ranking J1 procedure this is paid at a comprehensive rate and all other covered services on the bill are packaged with the primary "J1" procedure.

This code is assigned APC 5114. The OPSS 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 multiplied by 200% for a MAR of \$11,449.96.

- Procedure code 29881 has a status indicator of J1 and a ranking of 1,932. Only the highest ranking J1 procedure is eligible for payment.
- Procedure code 20680 has status indicator Q2 and is packaged into primary procedure.
- Procedure code J3010 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J1100 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J0690 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J1885 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J2250 has status indicator N, reimbursement is included with payment for the primary services.
- Procedure code J2405 has status indicator N, 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.
- Procedure code 96374 is packaged into primary procedure.

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

carrier paid \$11,449.96. 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

Signature

Medical Fee Dispute Resolution Officer

August 22, 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 electrónico CompConnection@tdi.texas.gov.