

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Doctor's Hospital at Renaissance

Respondent Name

Sentry Insurance Co

MFDR Tracking Number

M4-22-2480-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 26, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3, 2022	N455150016910ML	\$0.00	\$0.00
May 3, 2022	An Airway LMA Unique Sili	\$0.00	\$0.00
May 3, 2022	Dressing ABD Pad 8 x 10	\$0.00	\$0.00
May 3, 2022	76000	\$420.62	\$0.00
May 3, 2022	20680	\$4,167.14	\$0.00
May 3, 2022	29881	\$258.85	\$258.85
May 3, 2022	Anesthesia Gen Level	\$0.00	\$0.00
May 3, 2022	J2405	\$0.00	\$0.00
May 3, 2022	J1100	\$0.00	\$0.00
May 3, 2022	J2270	\$0.00	\$0.00
May 3, 2022	J1885	\$0.00	\$0.00
May 3, 2022	J0690	\$0.00	\$0.00
May 3, 2022	J2704	\$0.00	\$0.00
May 3, 2022	J2250	\$0.00	\$0.00
May 3, 2022	J3010	\$0.00	\$0.00
May 3, 2022	J2001	\$0.00	\$0.00
May 3, 2022	A9270	\$0.00	\$0.00
May 3, 2022	Recovery Room 1 st Hour	\$0.00	\$0.00
May 3, 2022	96374	\$373.96	\$0.00

	Total	\$5,220.57	\$258.85
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Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: \$5,220.57

Respondent's Position

The Austin carrier representative for Sentry Insurance Co is Flahive, Ogden and Latson. The representative was notified of this medical fee dispute on August 2, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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:

- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 131 – Claim specific negotiated discount

- PFL – Priced using a Coventry contract

Issues

1. Is the insurance carrier's reduction supported?
2. What rule applies for determining reimbursement for the disputed services?
3. Is the requester entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the payment based on negotiated discount. Review of the available information found insufficient evidence to support a negotiated rate. The disputed charges will be reviewed per applicable fee guidelines.
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).

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.

- Per Medicare policy, procedure code 76000 is packaged into comprehensive packaged code 29881.
- Procedure code 20680 is packaged into comprehensive packaged code 29881.
- Procedure code 29881 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 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 Medicare facility specific amount is \$2,588.42 multiplied by 200% for a MAR of \$5,176.84.

- Procedure code J2405 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 J2270 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 J0690 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2704 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 J3010 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2001 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.
- Per Medicare policy, procedure code 96374 is packaged into comprehensive packaged code 29881.

3. The total recommended reimbursement for the disputed services is \$5,176.84. The insurance carrier paid \$4,917.99. The amount due is \$258.85. 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 \$258.85 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 Sentry Insurance Co must remit to Doctors Hospital at Renaissance \$258.85 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	October 20, 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 electrónico CompConnection@tdi.texas.gov.