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
CRESCENT MEDICAL CENTER

Respondent Name
EMPLOYERS INSURANCE CO OF WAUSU

MFDR Tracking Number
M4-23-0082-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
September 8. 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 5, 2022	Code 62323	$269.62	$14.94

Requestor's Position

PRICED PER OPPS

EXPECTED ALLOWED $1531.80

ACTUAL ALLOWED $1262.18

PLEASE PAY THE ADDITIONAL $269.62

Amount in Dispute: $14.94

Respondent's Position

We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Act and Rules. This is not a network claim.

Response Submitted by: Liberty Mutual Insurance

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 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 193 – Original payment decision is being maintained. Upon review, it was determikned that this claim was processed properly. Original payment decision is being maintained, upon review, it was determined that this claim wa processed properly
- 4915 - The charge for the services represented by the code is included/bunlded ito the total facilty payment and odes not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- B13 – Previously paid, payment for this claim/service may have been provide in a previous payment

Issues

1. What is the recommended payment amount for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any outlier payments be multiplied by 200 percent for the Outpatient services in dispute. , unless a facility or surgical implant provider requests separate payment of implantables. Separate reimbursement for implants was not requested.

Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 62323 has status indicator T, for procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This code is paid at 100%. This code is assigned APC 5442. The OPPS Addendum A rate is $648.52. This is multiplied by 60% for an unadjusted labor amount of $389.11, in turn multiplied by facility wage index 0.9744 for an adjusted labor amount of $379.15. The non-labor portion is 40% of the APC rate, or $259.41. The sum of the labor and non-labor portions is $638.56. The Medicare facility specific amount is $638.56. This is multiplied by 200% for a MAR of $1,277.12.

2. The total recommended reimbursement for the disputed services is $1,277.12. The insurance carrier paid $1,262.18. The amount due is $14.94. 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 $14.94 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.

Authorized Signature

[redacted]

Signature	Medical Fee Dispute Resolution Officer	December 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.