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
La Joya ISD

MFDR Tracking Number
M4-23-0796-01

Carrier's Austin Representative
Box Number 29

DWC Date Received
December 5, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 2, 2022	N460687039579ML	$0.00	$0.00
August 2, 2022	Drsg Splint Plaster 5" Gr	$0.00	$0.00
August 2, 2022	A46222	$0.00	$0.00
August 2, 2022	Dressing Gauze 4"X4"	$0.00	$0.00
August 2, 2022	C1713	$0.00	$0.00
August 1, 2022	36415	$0.00	$0.00
August 1, 2022	80048	$0.00	$0.00
August 1, 2022	85027	$0.00	$0.00
August 2, 2022	25609	$0.00	$0.00
August 2, 2022	64721	$3,209.80	$0.00
August 2, 2022	Anesthesia Gen Level-1	$0.00	$0.00
August 2, 2022	J3010	$0.00	$0.00
August 2, 2022	J2250	$0.00	$0.00
August 2, 2022	J2450	$0.00	$0.00
August 2, 2022	J0690	$0.00	$0.00
August 2, 2022	J1100	$0.00	$0.00
August 2, 2022	J2704	$0.00	$0.00
August 2, 2022	A9270	$0.00	$0.00

August 2, 2022	Recovery Room 1ST Hour	$0.00	$0.00
August 2, 2022	96374	$373.96	$0.00
August 2, 2022	Total	$3,583.76	$0.00

Requestor's Position

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

Amount in Dispute: $3,583.76

Respondent's Position

"the allowance on this bill in dispute is correct per the OPPS fee guidelines.

Response submitted by: Dean G. Pappas

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:

- W3 – No additional reimbursement allowed after review of appeal/reconsideration
- P12 – Payment has been determined using the Clinical Laboratory Fee Schedule
- 96 – This code is not paid under outpatient PPS
- 97 – The service is considered incidental, packaged, or bundled into another service or APC payment
- P12 – The charge exceeds the APC rate for this service
- 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?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in August, 2022. The two disputed codes listed with amounts in dispute on the DWC60 are 64721 and 96374. The applicable reimbursement guideline for these codes is discussed 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 implantables.

   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 25609 has status indicator J1, for procedures paid at a comprehensive rate. The amount paid by the insurance carrier for this code is not in dispute.

   - Procedure code 64721 has a status indicator of J1. Per the Medicare payment policy found at www.cms.gov, Claims Processing Manual, Chapter Four, Section 10.2.3 which states, " *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.*

     Review of Addenda J of the OPPS Addenda at www.cms.gov, found procedure code 64721 has a ranking of 2,690. Procedure code 25609 has a ranking of 447. Per the Medicare payment policy only code 25609 is eligible for reimbursement.

   - Procedure code 96374 is included in the payment for the comprehensive J1 procedure.

No 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	December 30, 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.