

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Crescent Medical Center

Respondent Name

Liberty Mutual Fire Insurance Co

MFDR Tracking Number

M4-23-1229-01

Carrier's Austin Representative

Box Number 1

DWC Date Received

January 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 9, 2022	29827,29807,29823	\$1728.69	\$0.00
August 9, 2022	Implants Rev 0278	0.00	\$0.00
August 9, 2022	Other	0.00	\$0.00
	Total	\$1728.69	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "This bill was underpaid, please reprocess and pay the additional \$1728.69."

Amount in Dispute: \$1728.69

Respondent's Position

"Medicare facility specific amount for provider 670090 on CPT 29827 is \$6,225.10 x 130% = \$8092.63."

Response submitted by: Liberty Mutual

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:

- 11 – The recommended allowance for the supply was based on the attached invoice.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 3339 – Paid at fee schedule maximum. Modifier 22 requires unusual circumstances and supporting documentation.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.

Issues

1. What rule is applicable to disputed services?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of an outpatient hospital surgical procedure rendered in August 2022. 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 29827 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 5114. The OPPS 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 0.9552 for an adjusted labor amount of \$3,666.28.

The non-labor portion is 40% of the APC rate, or \$2,558.82.

The sum of the labor and non-labor portions is \$6,225.10.

The Medicare facility specific amount is \$6,225.10 is multiplied by 130% for a MAR of \$8,092.63.

2. The total recommended reimbursement for the disputed service is \$8,092.63. The insurance carrier paid \$8,092.63. 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

May 12, 2023

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.