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
Allmerica Financial Benefit Insurance Coi

MFDR Tracking Number
M4-23-1449-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
February 21, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 25, 2022	N455150015872ML	$0.00	$0.00
October 25, 2022	Drgs Splint Plaster 5" gR	$0.00	$0.00
October 25, 2022	A6222	$0.00	$0.00
October 25, 2022	Dressing gauze 4 x 4 st	$0.00	$0.00
October 25, 2022	C1713	$0.00	$0.00
October 21, 2022	0202U	$0.00	$0.00
October 21, 2022	36415	$0.00	$0.00
October 21, 2022	80048	$0.00	$0.00
October 21, 2022	85027	$0.00	$0.00
October 25, 2022	26765	$258.85	$0.00
October 25, 2022	11012	$0.00	$0.00
October 25, 2022	11012	$0.00	$0.00
October 25, 2022	11760	$239.35	$0.00
October 25, 2022	11760	$239.35	$0.00
October 25, 2022	11760	$239.35	$0.00
October 25, 2022	26765	$2,588.42	$0.00
October 25, 2022	26765	$2,588.42	$293.81
October 25, 2022	Anesthesia Gen Lever=1	$0.00	$0.00
October 25, 2022	94640	$0.00	$0.00

October 25, 2022	J1885	$0.00	$0.00
October 25, 2022	J2250	$0.00	$0.00
October 25, 2022	J2405	$0.00	$0.00
October 25, 2022	J3010	$0.00	$0.00
October 25, 2022	J2704	$0.00	$0.00
October 25, 2022	J0690	$0.00	$0.00
October 25, 2022	A9270	$0.00	$0.00
October 25, 2022	Recovery Room1st hour	$0.00	$0.00
October 25, 2022	96374	$373.96	$0.00
	Total	$6,527.70	$293.81

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,"According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $6,527.70

Respondent's Position

"In total, Requestor is seeking $6,527.70 in additional reimbursement from Carrier for date of service October 25, 2022. Carrier is standing by the reductions made by its bill review service as it believes those reductions to be proper."

Response submitted by: The Silvera Firm

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:

- P12 – A copy of an invoice showing the cost of the implant supplies/materials, device or durable medical equipment must be received. The invoicemust be specific to the patient,

show cost of aquisition, and/or cost of the product or equipment.

- 45 – A PPO reduction was mde for this bill and/or thie bill was repriced according to a negotiated rate.
- P12 – Payment has been determined using the Clincal Laboratory Fee Schedule.
- 96 – This code is not paid under outpatient PPS.
- P12 – The charge exceeds the APC rate for this service.

Issues

1. Is the insurance carrier's reduction and or denial supported?
2. What rule is applicable to disputed services?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered in October 2022. The insurance carrier reduced based on a PPO rate and workers'compensation jurisdiciation fee schedule.

   Review of the submitted information found insufficient evidence to support the injured worker is enrolled in a PPO. The calculation of the maximum allowable reimbursement (MAR) is discussed below.

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 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 26765 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure.
- The medical bill contained this code for three separate fingers but as this is a comprehensive procedure only a single payment is made.

  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 0.9744 for an adjusted labor amount of $1,690.94.

  The non-labor portion is 40% of the APC rate, or $1,156.91.

  The sum of the labor and non-labor portions is $2,847.85.

  The Medicare facility specific amount is $2,847.85 multiplied by 200% for a MAR of $5,695.70.
- Procedure code 11760 has a status indicator of T and is packaged into comprehensive J1 procedure.
- Procedure code 96374 has a status indicator of S and is packaged into comprehensive J1 procedure.

3. The total recommended reimbursement for the disputed services is $5,695.70. The insurance carrier paid $5,401.89. The amount due is $293.81. 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 $293.81 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 Allmerica Financial Benefit Insurance Co must remit to Doctors Hospital at Renaissance $293.81 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 7, 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 electronico CompConnection@tdi.texas.gov.