

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

Hartford Insurance Co of Illinois

MFDR Tracking Number

M4-23-1453-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

February 21, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 27, 2022	N455150015872ML	\$0.00	\$0.00
October 27, 2022	AN AIRWAY 100MM	\$0.00	\$0.00
October 27, 2022	Dressing Kerlix Roll Ster	\$0.00	\$0.00
October 27, 2022	A4622	\$0.00	\$0.00
October 26, 2022	0202U	\$0.00	\$0.00
October 26, 2022	36415	\$0.00	\$0.00
October 26, 2022	80048	\$0.00	\$0.00
October 26, 2022	85027	\$0.00	\$0.00
October 27, 2022	26952	\$782.75	\$518.86
October 27, 2022	15240	\$0.00	\$0.00
October 27, 2022	Anesthesia Gen Level-1 F1	\$0.00	\$0.00
October 27, 2022	J2250	\$0.00	\$0.00
October 27, 2022	J2405	\$0.00	\$0.00
October 27, 2022	J1885	\$0.00	\$0.00
October 27, 2022	J1100	\$0.00	\$0.00
October 27, 2022	J2704	\$0.00	\$0.00
October 27, 2022	J0690	\$0.00	\$0.00
October 27, 2022	A9270	\$0.00	\$0.00
October 27, 2022	Recovery room 1 st hour	\$0.00	\$0.00

October 27, 2022	96374	\$373.96	\$0.00
		Total	\$1,156.71
			\$518.86

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 guideline, 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: \$1,156.71

Respondent's Position

"The Requestor did not comply with all the provisions in DWC Rule 133.210. Submission of Medical Documentation, and the Carrier provided payment of the submitted bills and some reductions as allowed under DWC Rule 133.240."

Response submitted by: Ricky D. Green, PLLC

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:

- 93 – Non-covered services
- P12 – Workers' compensatuion jurisdictional fee schedule adjustment.

Issues

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

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered in October of 2022. The insurance carrier reduced the payment based on workers' compensation fee schedule.

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 26952, billed October 26, 2022, 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 0.9744 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 96374 has a status indicator of S. Reimbursement for this is included with payment for the primary procedure.

2. The total recommended reimbursement for the disputed services is \$5,695.70. The insurance carrier paid \$5,176.84. The amount due is \$518.86. 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 \$518.86 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 Hartford Insurance Co of Illinois must remit to Doctors Hospital at Renaissance \$518.86 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	March 31 . 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.