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
St Lukes Sugarland Hospital

Respondent Name
Metropolitan Transit Authority of Harris County

MFDR Tracking Number
M4-23-2505-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 25, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 10 -13, 2023	0252	$0.00	$0.00
January 10 -13, 2023	0258	$0.00	$0.00
January 10 -13, 2023	0272	$0.00	$0.00
January 10 -13, 2023	0278	$0.00	$0.00
January 10 -13, 2023	0300	$0.00	$0.00
January 10 -13, 2023	0360	$7610.41	$7,610.41
January 10 -13, 2023	0370	$0.00	$0.00
January 10 -13, 2023	0636	$0.00	$0.00
January 10 -13, 2023	0637	$0.00	$0.00
January 10 -13, 2023	0710	$0.00	$0.00
January 10 -13, 2023	0730	$0.00	$0.00
	Total	$7,610.41	$7,610.41

Requestor's Position

"Per the Addendum B- OPPS calculator the OR Service should pay $6273.84 X 200% = $12547.69. The implants were NOT requested to be paid separately. The carrier originally paid $4937.28 for the OR service. We submitted an appeal for underpayment with the Medicare allowable that shows what the markup should be along with a copy of the rule 134.404 stating

that only if the provider requests that implants be processed separately do they need to include the invoice. The carrier did not pay any additional amount and requested implant invoices. There is a balance left of $7610.41, this is the amount we are seeking for medical dispute."

Supplemental Response August 16, 2023.

"As of today no payment has been received."

Amount in Dispute: $7,610.41

Respondent's Position

"The carrier is in agreement with the provider. It has reprocessed the provider's bill. On June 12, 2023, it issued a check to the provider in the amount of $7,610.41. On that same date, it also issued a check in payment of interest in the amount of $88.29."

Response submitted by: Flahive Ogden & Latson

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:

- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is the requestor's position statement supported?
2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment for outpatient hospital services rendered in January 2023. The respondent submitted a copy of check number 2000032176 dated June 12, 2023 in the amount of $7610.41 The requestor indicated on August 16, 2023 payment has not been received. The submitted check copy did not indicate the check had been deposited by the requestor. The disputed service will be reviewed per applicable fee guideline.
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 found the following codes were submitted under Revenue Code 360. The codes will be reviewed per the applicable fee guidelines referenced above.

   - Procedure code 27658-RT has a status indicator of J1. The Medicare claims processing manual at www.cms.gov Chapter 4, Section 10.2.3, states in pertinent part, *Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS. – lower ranked comprehensive procedure codes (status indicator J1).*

     Procedure code 27658 has a ranking of 1,797. Code 27698 has a ranking of 496. Procedure code 27658 is packaged into higher ranking J1 code 27698.

- Procedure code 27675-RT has a ranking of 1,761 and is packaged into higher ranking J1 code 27698.
- Procedure code 27681-59 has a ranking of 2,022 and is packaged into higher ranking J1 code 27698.
- Procedure code 27698-RT 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 $6,614.63 multiplied by 60% for an unadjusted labor amount of $3,968.78, in turn multiplied by facility wage index 0.9925 for an adjusted labor amount of $3,939.01.

  The non-labor portion is 40% of the APC rate, or $2,645.85.

  The sum of the labor and non-labor portions is $6,584.86.

  The Medicare facility specific amount is $6,584.86 multiplied by 200% for a MAR of $13,169.72.
- Procedure code 29891-RT has a ranking of 1,814 and is packaged into higher ranking J1 code 27698.
- Procedure code 29898-RT has a ranking of 1,802 and is packaged into higher ranking J1 code 27698.

3. The total recommended reimbursement for the disputed services is $13,169.72. The insurance carrier paid $4,937.25. The requestor is seeking additional reimbursement of $7,610.41. 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 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $7,610.41 additional reimbursement for the disputed services. It is ordered that Metropolitan Transit Authority of Harris County must remit to St Lukes Sugarland Hospital $7,610.41 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 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.