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
National Fire Insurance Co of Hartford

MFDR Tracking Number
M4-23-2772-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
June 29, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 19, 2022	N400409488810ML	$0.00	$0.00
August 19, 2022	J7050	$0.00	$0.00
August 19, 2022	AN AIRWAY 90MM	$0.00	$0.00
August 19, 2022	Dressing Coban 6" X 5yds	$0.00	$0.00
August 19, 2022	L1830	$0.00	$0.00
August 19, 2022	C1713	$0.00	$0.00
August 19, 2022	Socket, insert, SM, 32MM	$0.00	$0.00
August 19, 2022	C1776	$0.00	$0.00
August 17, 2022	36415	$0.00	$0.00
August 17, 2022	0202U	$0.00	$0.00
August 17, 2022	83036	$0.00	$0.00
August 17, 2022	80053	$0.00	$0.00
August 17, 2022	85025	$0.00	$0.00
August 17, 2022	85610	$0.00	$0.00
August 17, 2022	85730	$0.00	$0.00
August 17, 2022	87088	$0.00	$0.00
August 17, 2022	81001	$0.00	$0.00
August 17, 2022	86900	$206.12	$0.00
August 17, 2022	86901	$61.88	$0.00

August 17, 2022	86850	$90.84	$0.00
August 19, 2022	88311	$0.00	$0.00
August 19, 2022	88304	$90.84	$0.00
August 19, 2022	73020-RT	$147.86	$0.00
August 19, 2022	23472-RT	$18,401.17	$2,576.54
August 19, 2022	Anesthesia Gen Level-1 F1	$0.00	$0.00
August 19, 2022	J3370	$0.00	$0.00
August 19, 2022	J2370	$0.00	$0.00
August 19, 2022	J2250	$0.00	$0.00
August 19, 2022	J3010	$0.00	$0.00
August 19, 2022	J2405	$0.00	$0.00
August 19, 2022	J0171	$0.00	$0.00
August 19, 2022	J1956	$0.00	$0.00
August 19, 2022	J1885	$0.00	$0.00
August 19, 2022	J2795	$0.00	$0.00
August 19, 2022	J2704	$0.00	$0.00
August 19, 2022	J2710	$0.00	$0.00
August 19, 2022	A9270	$0.00	$0.00
August 19, 2022	Recovery Room 1st hour	$0.00	$0.00
August 19, 2022	96374	$373.96	$0.00
	Total	$6,287.71	$2,576.54

Requestor's Position

The requestor did not submit a position statement with their request for Medical Fee Dispute Resolution (MFDR) but did submit a copy of their reconsideration that states in pertinent part, "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. After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $6,287.71

Respondent's Position

"Payment has been made in accordance with both the Original EOR and Revised EOR in the total amounts of allowable reimbursement, $19,963.94 as evidenced by the EOR/Revised EOR and attached payment history sheet. The Carrier has paid the recommended allowance in accord with Division Rules. No additional reimbursement is owed as disputed by the Requestor."

Response submitted by: Law Office of Brian J. Judis

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:

- 96 – Non-covered charge(s).
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 797 – Service not paid under Medicare OPPS.
- 877 – Reimbursement is based on the contracted amount.
- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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.
- 18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Did the respondent support the claimant is enrolled in a certified healthcare network?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered in August of 2022. The insurance carrier reduced the allowed amount based on a contract and PPO Reduction: Paradigm Retro P&T.

   Review of the available information found insufficient evidence to support the claimant is enrolled in a certified network that would result in this reduction. This reduction will not be considered in this dispute.

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 23472 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 5115.

     The OPPS Addendum A rate is $12,593.29 multiplied by 60% for an unadjusted labor amount of $7,555.97, in turn multiplied by facility wage index 0.8249 for an adjusted labor amount of $6,232.92.

     The non-labor portion is 40% of the APC rate, or $5,037.32.

     The sum of the labor and non-labor portions is $11,270.24.

The Medicare facility specific amount is $11,270.24 multiplied by 200% for a MAR of $22,540.48.

The total recommended reimbursement for the disputed services is $22,540.48. The insurance carrier paid $19,963.94. The amount due is $2,576.54. 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 $2,576.54 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 National Fire Insurance Co of Hartford must remit to Doctors Hospital at Renaissance $2,576.54 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

Authorized Signature

		July 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 electronico CompConnection@tdi.texas.gov.