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
Providence Sierra

Respondent Name
Travelers Indemnity Co of Connecticut

MFDR Tracking Number
M4-24-0215-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
September 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 6, 2023	26356-RT	$2,337.89	$0.00
	Total	$2,337.89	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for reconsideration. They did submit a copy of their reconsideration that states, "Based on the service(s) provided, we expected you to allow $7,802.21 for payment on this claim pursuant to the fee schedule in the contract. We received payment in the amount of $5,464.32 on this claim, with $00.00 identified as patient responsibility. Pursuant to your contractual obligations, you are required to make further payment in the amount of $2,337.89, which is the balance owed to us exclusive of patient responsibility."

Amount in Dispute: $2,337.89

Respondent's Position

"The Provider contends they are entitled to additional reimbursement for CPT code 26356-RT. The Carrier has reviewed the documentation and contends the Provider has been reimbursed at the appropriate amount. The primary code CPT code 26356-RT was reimbursed pursuant to the

applicable Medicare base rate and Division modifier. All other codes are inclusive to the primary coded procedure, except the implantables which are not documented on the operative report. The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated."

Response submitted by: Travelers

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:

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. .
- 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.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.

Issues

1. What rule is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in April, 2023. The insurance carrier reduced the payment based on packaging and the workers' compensation fee schedule. The requestor in their reconsideration states the payment was not per contract. Review of the submitted documentation found insufficient evidence to

support a contract between the two parties. The services in dispute 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 and the applicable fee guidelines referenced above is shown below.

- Procedure code 26356 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 $2,976.66 multiplied by 60% for an unadjusted labor amount of $1,786.00, in turn multiplied by facility wage index 0.8631 for an adjusted labor amount of $1,541.50.

  The non-labor portion is 40% of the APC rate, or $1,190.66.

  The sum of the labor and non-labor portions is $2,732.16.

  The Medicare facility specific amount is $2,732.16 multiplied by 200% for a MAR of $5,464.32.

2. The total recommended reimbursement for the disputed services is $5,464.32. The insurance carrier paid $5,464.32. 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		October 27, 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.