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
Space Exploration Technologies Corp

MFDR Tracking Number
M4-23-3352-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 25, 2023	N460687039579ML	$0.00	$0.00
April 25, 2023	AN AIRWAY 100MM	$0.00	$0.00
April 25, 2023	Dressing ABD pad 8"x10"	$0.00	$0.00
April 25, 2023	L1830	$0.00	$0.00
April 25, 2023	C1713	$0.00	$0.00
April 25, 2023	36415	$0.00	$0.00
April 25, 2023	0202U	$0.00	$0.00
April 25, 2023	80051	$0.00	$0.00
April 25, 2023	85027	$0.00	$0.00
April 25, 2023	29888	$7017.86	$7734.42
April 25, 2023	29882	$0.00	$0.00
April 25, 2023	29881	$0.00	$0.00
April 25, 2023	Anesthesia Gen Level-1 FI	$0.00	$0.00
April 25, 2023	94640	$344.72	$0.00
April 25, 2023	J3010	$0.00	$0.00
April 25, 2023	J2405	$0.00	$0.00
April 25, 2023	J1100	$0.00	$0.00
April 25, 2023	J1885	$0.00	$0.00
April 25, 2023	J0690	$0.00	$0.00
April 25, 2023	J2704	$0.00	$0.00

April 25, 2023	J2270	$0.00	$0.00
April 25, 2023	A9270	$0.00	$0.00
April 25, 2023	Recover Room 1st hour	$0.00	$0.00
April 25, 2023	96374	$371.84	$0.00
	Total	$7734.42	$7734.42

Requestor's Position

The requestor did not include a position statement with this request for MFDR. They 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. After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $7734.42

Respondent's Position

"The Requestor is an in-network member of the CorVel Texas CorCare Certified Healthchare [sic] Network (Corvel TXHCN) effective 06/28/2018. A copy of the EOR identifying the network as well as the use of CARC 45 alert the provider to the application of their network agreement is attached… The complaint process outlined in Texas Insurance Code Subchapter 1, §135.401 - §1305.405 may be the appropriate administrative remedy to address fee matters related to health care certified networks. To date CorVel has no evidence of a network complaint filed by the Requestor for disputed service 04/25/2023 in the amount of $27,161.46…"

Response submitted by: CorVel

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 Texas Administrative Code (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 disputed service(s) with the following claim adjustment codes.

- 00 – CCI Edit reviewed and suppressed.

- 234 – This procedure is not paid separately.
- 59 – Distinct Procedural Service
- 97 – Charge Included in another Charge or Service.
- P14 – Payment is included in another svc/procdre occurring on same day.
- W3 – Appeal/Reconsideration.
- 45 – Contract/Legislated Fee Arrangement Exceeded.
- 96 – Non-Covered Charges.

Issues

1. Is the insurance carrier's position supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in April of 2023. The respondent states in their position statement, "The Requestor is an in-network member of the CorVel Texas CorCare Certified Healthchare [sic] Network…" Review of the submitted DD form indicates the claim is not through a certified workers' compensation health care network. Review of this information and information known to the Division finds insufficient evidence to support the injured worker and health care provider are participants in a certified healthcare network. The services in dispute will be reviewed per applicable fee guidelines.
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)(2) states in pertinent part, **regardless of billed amount**, if no contracted fee schedule exits that complies with Labor Code §413.011, 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 sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found a request for implants was not made. The Medicare facility specific reimbursement amount will be multiplied by 200 percent.

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.

- Per Medicare policy, procedure code L1830 is included in the comprehensive J1 procedure. Separate payment is not recommended.
- Procedure code C1713 is included with payment for the primary services. Separate reimbursement of implants not requested.
- Per Medicare policy, procedure code 36415 is included in the comprehensive J1 procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 0202U is included in the comprehensive J1 procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 80051 is included in the comprehensive J1 procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 85027 is included in the comprehensive J1 procedure. Separate payment is not recommended.
- Procedure code 29888 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 in combination with code 29882 qualifies for complexity adjustment per Addenda "J" at www.cms.gov. This combination is assigned APC 5115. The OPPS Addendum A rate is $13,048.08 multiplied by 60% for an unadjusted labor amount of $7,828.85, in turn multiplied by facility wage index 0.8334 for an adjusted labor amount of $6,524.56.

  The non-labor portion is 40% of the APC rate, or $5,219.23.

  The sum of the labor and non-labor portions is $11,743.79.

  The Medicare facility specific amount is $11,743.79 multiplied by 200% for a MAR of

$23,487.58.

- Per Medicare policy, procedure code 29882 is included with payment for the comprehensive J1 procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 29881 is included with payment for the comprehensive J1 procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 94640 is included with payment for the comprehensive J1 procedure. Separate payment is not recommended.
- Procedure code J3010 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2405 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J1100 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2250 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J1885 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J0690 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2704 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2710 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2270 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code A9270 has status indicator E1, for excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Per Medicare policy, procedure code 96374 is included with payment for the comprehensive J1 procedure. Separate payment is not recommended.

3. The total recommended reimbursement for the disputed services is $23,487.58. The insurance carrier paid $5,181.17. The requestor is seeking additional reimbursement of $7,734.42. 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 additional reimbursement for the disputed services. It is ordered that Space Exploration Technologies Corp must remit to Doctors Hospital at Renaissance $7,734.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 25, 2024
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.