



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

Service Lloyds Insurance Co

MFDR Tracking Number

M4-24-0185-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

September 25, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 11, 2023	20680	\$1,795.23	\$378.57
May 11, 2023	96374	\$371.84	\$0.00
Total		\$2,167.07	\$378.57

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 guidelines, 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: \$2,167.07

Respondent's Position

"This request will be standing on the fee schedule allowance of \$5024.16, and we verified an additional allowance is recommended per PPO Coventry Integrated Network for an additional allowance of \$1193.56. However, the additional monies sought by the provider are per the PPO discount and Medical fee dispute resolution is the improper venue."

Response submitted by: Mitchell

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 reimbursement guidelines for outpatient hospital services.

Denial Reasons

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup.
- J49 – The allowance for this line has been summed with other allowances on the bill and re-distributed evenly.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 131 – Claim specific negotiated discount.
- PDC – This bill was reviewed in accordance with your Coventry contract.
- PK2 – Subject to Coventry workers comp network. A certified TX HCN.
- 236 – This procedure or procedure modifier combination is not compatible with another procedure or procedure modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.

Issues

1. Is the insurance carrier's reduction supported?

2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of outpatient hospital services rendered May of 2023. Specifically, code 20680 and 96374 are the only codes listed on the DWC60 that indicate an amount in dispute. The insurance carrier made payment but reduced the allowed amount on the claim stating, specific negotiated discount and Coventry network. Review of the submitted documentation and information known to the Division found insufficient evidence to support that the injured worker is enrolled in a certified healthcare network. The insurance carrier's reduction is not supported.
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 exists 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 is not applicable.

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 20680 has status indicator Q2, for T-packaged codes. This code is

assigned APC 5073. The OPSS Addendum A rate is \$2,583.25 multiplied by 60% for an unadjusted labor amount of \$1,549.95, in turn multiplied by facility wage index 0.8334 for an adjusted labor amount of \$1,291.73.

The non-labor portion is 40% of the APC rate, or \$1,033.30.

The sum of the labor and non-labor portions is \$2,325.03.

The Medicare facility specific amount is \$2,325.03 multiplied by 200% for a MAR of \$4,650.06.

- Procedure code 96374 has a status indicator of Q1 and is packaged into primary procedure. No separate allowance is recommended.
3. The total recommended reimbursement for the disputed services is \$4,650.06. The insurance carrier paid \$4,271.49. The amount due is \$378.57. 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 has been ordered that Service Lloyds Insurance Co must remit to Doctors Hospital at Renaissance \$378.57 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	December 17, 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 electrónico CompConnection@tdi.texas.gov.