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
University Medical Center

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-24-1003-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 10, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 24, 2023	02050	$0.00	$0.00
July 24, 2023	0278	$0.00	$0.00
July 24, 2023	0481/CPT 33285	$465.53	$0.00
July 24, 2023	0710	$0.00	$0.00
	Total	$0.00	$0.00

Requestor's Position

"This is a bill for an outpatient procedure on July 24, 2023, and included medical/surgical supplies. Per the Addendum B-OPPS calculator CPT 33285 should pay $7,609.95 x 200% = $15,219.91."

Amount in Dispute: $465.53

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for bill review audit and payment. Supplemental response will be provided once the bill auditing company has finalized their review."

Supplemental response February 22, 2024

"Our bill audit company has determined that the provider is not due any additional allowance because the previous bill was not processed correctly per the TX Fee Schedule."

Response submitted by: Gallagher Bassett

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.

- 5721 – To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests, submit a copy of this EOR or clear notation.
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- P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment.
- 5403 – CV: This bill qualified for the Clinical Validation Program, no reductions applied.
- 6183 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the PA.
- 6340 – Charge for this procedure exceeds the OPPS schedule allowance.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What rule is applicable to reimbursement?

2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in July of 2023. The insurance carrier reduced the disputed service based on workers compensation jurisdictional fee schedule. The applicable fee schedule calculation is shown below.

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 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. The submitted medical bill did not contain a request for separate implant reimbursement.

   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 C1764 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

   - Procedure code 33285 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 5222. The OPPS Addendum A rate is $8,162.77 multiplied by

60% for an unadjusted labor amount of $4,897.66, in turn multiplied by facility wage index 0.8372 for an adjusted labor amount of $4,100.32.

The non-labor portion is 40% of the APC rate, or $3,265.11.

The sum of the labor and non-labor portions is $7,365.43.

The Medicare facility specific amount is $7,365.43 multiplied by 200% for a MAR of $14,730.86.

2. The total recommended reimbursement for the disputed services is $14,730.86. The insurance carrier paid $14,754.38. 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 5, 2024 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.