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
Texas Association of Counties Risk Mgmt

MFDR Tracking Number
M4-24-1607-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
March 25, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 30, 2023	27429	$11.96	$0.00
November 30, 2023	29877	$2679.12	$0.00
November 30, 2023	96374	$371.84	$0.00
	Total	$3,471.28	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for reconsideration however, they did submit a copy of their reconsideration dated February 20, 2024 that states, "After reviewing the account we have concluded that reimbursement received was inaccurate. …reimbursement should be $26,958.90. Payment received was only $23,487.62, thus, according to these calculations; there is a pending payment in the amount of $3,471.28."

Amount in Dispute: $3,471.28

Respondent's Position

"As reflected in the EOBs, Texas Association of Counties Risk Management Pool properly reimbursed Doctors Hospital at Renaissance in accordance with the Texas Workers' Compensation Act and Division Rules and contends that no further reimbursement is owed for

the dates of service in question."

Response submitted by: Burns Anderson Jury & Brenner L.L.P.

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.

- 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.
- 797 – Service not paid under Medicare OPPS.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 906- In accordance with clinical based coding edits (National correct coding initiative/outpatient code editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- 96 – Non-covered charges(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.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- N569 – Not covered when performed for the reported diagnosis.
- N702 – Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of service.

- N600 – Adjusted based on the applicable fee schedule for the region in which the service was received.

Issues

1. Is the insurance carrier's reduction/denial supported?

2. What rule is applicable to reimbursement?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services. While the DWC60 lists many codes, the following codes are shown to be in dispute, 27429, 29877 and 96374. The insurance carrier reduced the code 27429 based on Texas Workers' Compensation fee schedule and denied codes 29877 and 96374 based on packaging. Review of the applicable DWC fee guidelines provisions is found 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)(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. The submitted medical bill did not contain a request for separate implant reimbursement. The facility specific reimbursement 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.

- Procedure code 27429 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure.

  The Medicare payment policy regarding J1 codes allows payment for the highest ranking J1 procedure. Review of Addenda J at www.cms.gov found code 27429 has a ranking of 157. Code 29877 has a ranking of 1,916. Code 27429 is the highest ranking and receives the comprehensive payment.

  This code 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.

- As shown above procedure code 29877 is packaged into the primary J1 procedure.

- Procedure code 96374 has a status indicator of S and is packaged into primary J1 procedure.

3. The total recommended reimbursement for the disputed services is $23,487.58. The insurance carrier paid $23,487.62. 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

		April 30, 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.