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
TX HEALTH OF STEPHENVILLE

Respondent Name
TRAVELERS INDEMNITY CO OF AMERICA

MFDR Tracking Number
M4-24-1747-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
April 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 27, 2023	Hospital Outpatient	$1,957.98	$1,043.78
	Total	$1,957.98	$1,043.78

Requestor's Position

"Attached is a copy of an EOB, UB04, and an itemized statement, and medical records. The claim referenced below was billed with CPT Code 29827, and the Medicare reimbursement is $6895.12 as referenced in the copy of the Medicare Pricer included in this request. We are in receipt of a payment of $11,832.26, however this claim was underpaid by $1,957.98. Our calculations are based on the Medicare outpatient rates for CPT code 29827 which is $6,895.12 and the outpatient work comp fee schedule allowance is $13,790.24, and finally deducting the payment $11,832.26, leaves an unpaid balance due of $1,957.98."

Amount in Dispute: $1,957.98

Respondent's Position

"The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for an outpatient surgical procedure. The Provider repaired a… injury and submitted billing. The Carrier reviewed the billing and issued reimbursement. After reviewing the Provider's request for reconsideration, the Carrier maintained the original reimbursement determination. Subsequently the Provider filed this Request for Medical Fee Dispute Resolution."

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 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.

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 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.
- P12 – Workers' Compensation Jurisdictional Fee Schedule adjustment.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 4097 – Paid per fee schedule charge adjusted because statute dictates allowance is greater than provider's charge.

Issues

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

Findings

1. The requestor is seeking additional payment of $1,957.98 for outpatient hospital services rendered on July 27, 2023.

   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.

   - Procedure code C1713 has status indicator N reimbursement is included with payment for the primary services.
   - Procedure code 29823 has a status indicator of J1. Medicare payment policy allows for payment of the highest ranking J1 procedure. Review of Addenda J at www.cms.gov found code 29832 has a ranking of 1,776. This is not the highest ranking J1 procedure. Payment is packaged into code 29827.

- Procedure code 29827 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. Review of Addenda J at www.cms.gov, found this code is ranked 485. This is the highest ranking J1 procedure and receives payment.

  This code is assigned APC 5114. The OPPS Addendum A rate is $6,614.63 multiplied by 60% for an unadjusted labor amount of $3,968.78, in turn multiplied by facility wage index 0.9555 for an adjusted labor amount of $3,792.17.

  The non-labor portion is 40% of the APC rate, or $2,645.85.

  The sum of the labor and non-labor portions is $6,438.02.

  The Medicare facility specific amount is $6,438.02 multiplied by 200% for a MAR of $12,876.04.

- Procedure code 29828 has a status indicator of J1. Medicare payment policy allows for payment of the highest ranking J1 procedure. Review of Addenda J at www.cms.gov found code 29828 has a ranking of 576. This is not the highest ranking J1 procedure. Payment is packaged into code 29827.

- Per Medicare policy, procedure code 64415 has a status indicator of T and is packaged into the primary J1 procedure.

- Procedure code J0171 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J0171 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J0330 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 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 J2371 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 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 J2795 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J3010 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J7120 has status indicator N reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is $12,876.04. The insurance carrier paid $11,832.26. The amount due is $1,043.78. 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 TRAVELERS INDEMNITY CO OF AMERICA must remit to TX HEALTH OF STEPHENVILLE $1,043.78 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted]

May 1 , 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, 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.