



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

Texas Associated of Counties Risk Mgmt

MFDR Tracking Number

M4-24-2279-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

June 14, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 1, 2023	72040	\$147.86	\$0.00
September 1, 2023	73590	\$147.86	\$0.00
September 1, 2023	99284	\$664.98	\$0.00
Total		\$960.70	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a reconsideration dated January 30, 2024 that states, "(injured worker) registered only with her private insurance Health First TPA. Bill was submitted and paid by Health First TPA then on 11/14/2023 a request from Health First for a refund was requested stating service should be covered under work related injury Sedgwick."

Supplemental response submitted September 16, 2024.

"No payment has been received. Please keep MDR request open."

Amount in Dispute: \$960.70

Respondent's Position

"Initially, an error was made in the processing of the disputed bill. However, after re-processing the bill, reimbursement of \$843.32 was calculated. As reflected in the attached 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 no further reimbursement is owed."

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 reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 1002 – Due to an error in processing the original bill, we are recommending further payment be made for the above noted procedure.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal /reconsideration.
- 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 status indicator determines the service is packaged or excluded from payment.
- 6514 – Timely Filing denial reconsidered.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 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.

- W3 – Bill is a reconsideration or appeal.

Issues

1. Did the insurance carrier support payment of the disputed services.
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 in September of 2023. The insurance carrier submitted documentation to support a payment of \$843.32 was made on June 28, 2024 via Electronic Fund Transfer (EFT). EFT tracer number 2369188. The requestor maintained their request for MFDR.
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 implants are not applicable. 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 72040 has a status indicator of Q1 and is packaged in APC of 5024 for code 99284 submitted on the medical bill. No separate payment is recommended.
- Procedure code 73590 has a status indicator of Q1 and is packaged in APC of 5024 for code 99284 submitted on the medical bill. No separate payment is recommended.
- Procedure code 99284 has a status indicator of J2 but only when the criteria of comprehensive observation is met. Review of the submitted documentation found observation hours were not rendered or billed. Code 99284 is assigned APC 5024. The OPPS Addendum A rate is \$381.61 multiplied by 60% for an unadjusted labor amount of \$228.97, in turn multiplied by facility wage index 0.8334 for an adjusted labor amount of \$190.82.

The non-labor portion is 40% of the APC rate, or \$152.64.

The sum of the labor and non-labor portions is \$343.46.

The Medicare facility specific amount is \$343.46 multiplied by 200% for a MAR of \$686.92.

3. The total recommended reimbursement for the disputed services is \$686.92. The insurance carrier supported payment of \$843.32. No additional payment 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 not established that additional reimbursement is due.

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 11, 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 electrónico CompConnection@tdi.texas.gov.