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
Sentinel Insurance Company Ltd

MFDR Tracking Number
M4-24-2288-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
June 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 31, 2024	N470092912043ML	0.00	$0.00
January 31, 2024	36415	0.00	$0.00
January 31, 2024	80048	0.00	$0.00
January 31, 2024	85025	0.00	$0.00
January 31, 2024	85610	0.00	$0.00
January 31, 2024	85730	0.00	$0.00
January 31, 2024	86850	0.00	$0.00
January 31, 2024	86900	0.00	$0.00
January 31, 2024	86901	0.00	$0.00
January 31, 2024	72170	193.88	$0.00
January 31, 2024	73030	160.26	$0.00
January 31, 2024	71045	160.26	$0.00
January 31, 2024	23655	0.00	$0.00
January 31, 2024	99285	1412.06	$0.00
January 31, 2024	J2405	0.00	$0.00
January 31, 2024	ED Trauma Team Level 2	0.00	$0.00
January 31, 2024	96374	378.00	$0.00
	Total	$2,304.43	$0.00

Requestor's Position

"The requestor did not submit a position statement with this request for MFDR. They 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: $2,304.43

Respondent's Position

"The original bill for dos 1/31/24 received on 4/9/24 processed and paid per OPPS schedule and/or services were bundled/included."

Response submitted by: The Hartford

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.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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.
- 3244 – The billing of the procedure code has exceeded the national correct coding initiative medically unlikely edits amount for the number of time this procedure can be billed on a date of service. An allowance has not been paid.
- 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.

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 emergency room services. The insurance carrier reduced the disputed service based on packaging and workers compensation fee schedule. The fee calculation based on applicable DWC guidelines is shown below.

   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 implants are 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 36415 has a status indicator of Q4. Packaged into primary J1 procedure.
- Procedure code 80048 has a status indicator of Q4. Packaged into primary J1 procedure.
- Procedure code 85025 has a status indicator of Q4. Packaged into primary J1 procedure.
- Procedure code 85610 has a status indicator of Q4. Packaged into primary J1 procedure.
- Procedure code 85730 has a status indicator of Q4. Packaged into primary J1 procedure.
- Procedure code 86850 has a status indicator of Q4. Packaged into primary J1 procedure.
- Procedure code 86900 has a status indicator of Q4. Packaged into primary J1 procedure.
- Procedure code 86901 has a status indicator of Q4. Packaged into primary J1 procedure.
- Procedure code 72170 has status indicator Q1. Packaged into primary J1 procedure.
- Procedure code 73030 has status indicator Q1. Packaged into primary J1 procedure.
- Procedure code 71045 has status indicator Q3. Packaged into primary J1 procedure.
- Procedure code 23644 has a status indicator J1. All other services are packaged into primary comprehensive procedure.

  APC 5112 with payment rate $1,531.31 multiplied by wage index for provider 450869 0.8758 equals adjusted labor rate of $804.68

  Non-labor rate 40% of APC rate equals $612.53

  Sum of adjusted and non-adjusted labor rate equals $1417.21.

  The Medicare provider specific rate of $1417.21 multiplied by 200% equals a MAR of $2834.42

- Procedure code 99285 has an APC of V and is packaged into primary J1 procedure.
- Procedure code J2405 has status indicator N. Packaged into primary J1 procedure.
- Procedure code 96374 has a status indicator of S and is packaged into primary procedure.

2. The total recommended reimbursement for the disputed services is $2834.42. The insurance carrier paid $2834.44. 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 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	July 17, 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.