TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-24-2305-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 20, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 26, 2024	N400409116501ML	$0.00	$0.00
March 26, 2024	DRSG SPLINT PLASTER 5" GR	$0.00	$0.00
March 26, 2024	A4622	$0.00	$0.00
March 26, 2024	DRESSING GAUZE 4" X 4" ST	$0.00	$0.00
March 26, 2024	C1713	$0.00	$0.00
March 25, 2024	36415	$0.00	$0.00
March 25, 2024	80048	$0.00	$0.00
March 26, 2024	82962	$0.00	$0.00
March 25, 2024	85027	$0.00	$0.00
March 26, 2024	26565	$2944.71	$1,456.38
March 26, 2024	ANESTHESIA GEN LEVEL 1 F1	$0.00	$0.00
March 26, 2024	J3010	$0.00	$0.00
March 26, 2024	J1170	$0.00	$0.00
March 26, 2024	J2405	$0.00	$0.00
March 26, 2024	J2250	$0.00	$0.00
March 26, 2024	A9270	$0.00	$0.00
March 26, 2024	RECOVERY ROOM 1ST HOUR	$0.00	$0.00
March 26, 2024	96374	$378.00	$0.00
	Total	$1,834.38	$1,456.38

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 guideline, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. After reviewing the account we have concluded that reimbursement received was inaccurate. …there is a pending payment in the amount of $1,834.38."

Amount in Dispute: $1,834.38

Respondent's Position

The Austin carrier representative for American Zurich Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on June 25, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response submitted by: N/A

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 billing and reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 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.
- 877 – Reimbursement is based on the contracted amount.

- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 96 – Non-covered charge(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.
- 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined tat this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.

Issues

1. What services are in dispute?
2. Did the respondent support the injured worker is enrolled in a certified network?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in March of 2024. The DWC60 submitted details numerous line items. However, only two of the line items listed indicate a disputed amount. The two codes that will be considered in this review are 26565 and 96374.
2. The insurance carrier's explanation of benefits indicates a reduction made as reimbursement made based on contracted amount and an explanation of, "Network Reduction: Coventry P&T." Review of the information known to the Division and the submitted documentation found insufficient evidence to support the injured worker is enrolled in a certified network or that a contract exists between the two parties. The insurance carrier's reduction is not supported.
3. 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, 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 26565 has status indicator J1. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5113. The OPPS Addendum A rate is $3,084.03 multiplied by 60% for an unadjusted labor amount of $1,850.42, in turn multiplied by facility wage index 0.8758 for an adjusted labor amount of $1,620.60.

  The non-labor portion is 40% of the APC rate, or $1,233.61.

  The sum of the labor and non-labor portions is $2,854.21.

  The Medicare facility specific amount is $2,854.21 multiplied by 200% for a MAR of $5,708.42.

- Procedure code 96374 is packaged into primary J1 procedure shown above. No reimbursement is recommended.

3. The total recommended reimbursement for the disputed services is $5,708.42. The insurance carrier paid $4,252.04. The amount due is $1,456.38. 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 American Zurich Insurance Co must remit to Doctors Hospital at Renaissance $1,456.38 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

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 electronico CompConnection@tdi.texas.gov.