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
Employee Assurance Co

MFDR Tracking Number
M4-24-2366-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
June 25, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 1, 2024	71045	$ 160.26	$0.00
February 1, 2024	29828	$12616.76	$0.00
February 1, 2024	29826	$6308.38	$0.00
February 1, 2024	93005	$107.88	$0.00
February 1, 2024	96374	$378.00	$0.00
	Total	$19,571.28	$0.00

Requestor's Position

The requestor did not submit a position statement. They did submit a copy of their reconsideration dated May 9, 2024 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: $19,571.28

Respondent's Position

"It has been determined that no additional allowance is due at this time. CPT code 29827 paid according to the fee schedule (full charge amount). Remaining requested codes are inclusive

within total facility payment."

Response submitted by: Conduent

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.
- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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.
- 5281 – Non covered services.
- 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.
- 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.

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 hospital services rendered in February of 2024. The insurance carrier reduced the disputed services based on packaging, workers' compensation fee guidelines. The disputed services will be reviewed per applicable fee guidelines.

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. Review of the submitted medical bill found no separate request for implant reimbursement.

   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 71045 has status indicator Q3 and is packaged into primary J1 procedure.

   - Procedure code 29826 has status indicator N, for packaged codes, reimbursement is included with payment for the primary services.

- 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.

- The Medicare payment policy assigns rankings to J1 procedures to determine which procedure is ranked highest to determine if payable. Review of addenda J at www.cms.gov finds this code has a ranking of 515. As the highest ranking J1 procedure on the medical bill, this code receives payment.

  This code is assigned APC 5114. The OPPS Addendum A rate is $6,816.33 multiplied by 60% for an unadjusted labor amount of $4,089.80, in turn multiplied by facility wage index 0.8758 for an adjusted labor amount of $3,581.85.

  The non-labor portion is 40% of the APC rate, or $2,726.53.

  The sum of the labor and non-labor portions is $6,308.38.

  The Medicare facility specific amount is $6,308.38 multiplied by 200% for a MAR of $12,616.76.

- Procedure code 29828 has a status indicator of J1. As above, the applicable Medicare payment policy only allows payment of the highest ranking J1 procedure. Review of addenda J at www.cms.gov finds this code is ranked 637. This is not the highest ranked J1 procedure, separate payment is not recommended.

- Procedure code 93005 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.

- Procedure code G0378 has status indicator N, for packaged codes included with payment for the primary services.

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

2. The total recommended reimbursement for the disputed services is $12,616.76. The insurance carrier paid $12,616.78. 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 24, 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.