



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

TASB Risk Management Fund

MFDR Tracking Number

M4-25-0001-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

September 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 25, 2024	29881	\$2,854.21	\$0.00
April 25, 2024	29888	\$0.00	\$0.00
April 19 – 25, 2024	Outpatient Facility Medical Services	\$0.00	\$0.00
	Total	\$2,854.21	\$0.00

Requestor's Position

"After reviewing the account, we have concluded that reimbursement received was inaccurate. Based on CPT Code 29888, allowed amount of \$6308.38, multiplied at 200% and CPT Code 29881, allowed amount of \$2854.21 x .5, multiplied at 200% reimbursement should be \$15,470.97. Payment received was only \$12,616.75, thus, according to these calculations; there is a pending payment in the amount of \$2854.22."

Amount in Dispute: \$2,854.21

Respondent's Position

"Per the additional documentation received we stand on previous payment of \$ 12,616.75 as full payment. If the Primary J1 procedure is present with secondary (represented by a different procedure or multiple units of the same primary procedure) in a specified combination on the claim, assign the comprehensive APC representing the complexity adjustment to the primary J1 procedure. All other comprehensive procedures with SI=J1 on the same claim are packaged. We are not showing that CPT 29881 LT should be separately payable per the supporting documentation received."

Response submitted by: TASB Risk Management Fund

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.

Adjustment Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 618 - THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 305 - THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 617 - THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE.
- 97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- P13 - PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES.
- U03 - THE BILLED SERVICE WAS REVIEWED BY UR AND AUTHORIZED.

- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 351 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What rules apply to the service in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This medical fee dispute involves outpatient facility charges rendered on April 25, 2024.

DWC Rule 28 TAC §134.403, which sets out the fee guidelines for outpatient hospital services, states in pertinent part, "(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section..."

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 (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 following minimal modifications shall be applied. (1) 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..."

2. The requestor is seeking additional reimbursement in the amount of \$2,854.21 for CPT code 29881 rendered on April 25, 2024. On the date of service in dispute, the requestor rendered outpatient surgery services billed under CPT codes 29888 and 29881. Per Medicare OPPS Addendum B, both codes have an APC status indicator of J1, for outpatient comprehensive packaging.

For codes designated with payment status indicator J1, a single payment is provided for the primary service, and payment for all adjunctive services reported on the same claim are

packaged into the payment for the primary service.

The CPT code 29888 is described as a knee surgery procedure, arthroscopically aided anterior cruciate ligament repair, augmentation or reconstruction. Per Medicare Addendum J CY2024, which lists the ranks used to determine primary assignment of comprehensive HCPCS codes, code 29888 has a ranking of 454.

The CPT code 29881 is described as an arthroscopy procedure that involves surgical repair of a torn meniscus in the knee. Per Medicare Addendum J CY2024, which lists the ranks used to determine primary assignment of comprehensive HCPCS codes, code 29881 has a ranking of 1,977.

DWC finds that of the two surgical codes billed on the disputed claim, CPT code 29888 is the only payable code, as it is ranked as primary, under which all other services billed on the same claim are packaged for payment.

Per the explanation of benefits submitted, the insurance carrier previously issued a payment in the amount of \$12,616.75 for the primary ranked code, 29888, rendered on April 25, 2024.

According to the Medical Fee Dispute Resolution Request (form DWC060) submitted, CPT code 29881 is the only service in dispute. DWC finds that for the reasons indicated above, the requestor is not entitled to reimbursement for the disputed service of CPT code 29881 rendered on April 25, 2024.

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 that the requestor has not established that additional reimbursement is due.

Order

Under the Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement in the amount of \$0.00.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 9, 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.