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
Norguard Insurance Co

MFDR Tracking Number
M4-25-0268-01

Carrier's Austin Representative
Box Number 12

DWC Date Received
September 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 2, 2024	26860	$1997.95	$0.00
May 2, 2024	20680	$5011.20	$0.00
May 2, 2024	96374	$378.00	$0.00
	Total	$7,387.15	$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."

Supplemental response submitted December 27, 2024

"We received payment but that was for the surgery for underpaid (total charges of $22,249.65). MDR submission was for the ER visit total charges of $1,122.70. (Redacted injured worker's name) returned to hospital through ER due to complication from surgery…"

Amount in Dispute: $7,387.15

Respondent's Position

"This dispute has been determined to be owed to the provider as depicted in the attached dispute. However, for CPT code 20680, this will be paid in full at billed charges of $3,983.79 instead of $5,011.20 as we do not pay over charges in Texas. This bill has been reprocessed and payment for an additional $6,359.74 was sent to the provider with check # 010397672 on 11/12/2024."

Response submitted by: Norguard Insurance Company, November 20, 2024

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 rules and fee guidelines for outpatient hospital services.

Denial Reasons

- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 617 – This item or service is not covered or payable under the Medicare outpatient fee schedule.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline.
- 97 – 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 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the requestor submit a separate request to MFDR for emergency services?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor submitted a statement of, "MDR submission was for the ER visit total charges of $1,122.70. (Redacted injured worker's name) returned to hospital through ER due to complication from surgery…" Review of the submitted DWC60 did not list any emergency room services nor did the submitted medical bill for dates of service May 2, 2024. No additional medical bills or explanation of benefits were found with documents submitted to MFDR. This statement will not be considered in this dispute.
2. The requestor is seeking payment of the following codes listed with an amount in dispute on the DWC60.
    - 26860 – Amount in dispute $1.997.95
    - 20680 – Amount in dispute $5.011.20
    - 96374 – Amount in dispute $378.00

    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 a request for implants is 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 are shown below.

- Procedure code 26860 has status indicator J1, for procedures paid at a comprehensive rate. 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 0.8249 for an adjusted labor amount of $1,526.41.

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

  The sum of the labor and non-labor portions is $2,760.02.

  The Medicare facility specific amount is $2,760.02 multiplied by 200% for a MAR of $5,520.04.
- Procedure code 20680 has status indicator Q2, for T-packaged codes; reimbursement is packaged with payment for the J1 procedure shown above.
- Procedure code 96374 has a status indicator of S and is packaged with the payment for the J1 procedure shown above..

3. The total recommended reimbursement for the disputed services is $5,520.04. The insurance carrier paid $10,070.21. Additional payment is not 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

		January 16, 2025
Signature	Medical Fee Dispute Resolution Officer	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.