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
University Medical Center

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-25-0591-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
November 8, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 29 2024 – April 5, 2024	0250	$0.00	$0.00
March 29 2024 – April 5, 2024	0300	$0.00	$0.00
March 29 2024 – April 5, 2024	0301	$0.00	$0.00
March 29 2024 – April 5, 2024	0360/cpt 29881	$974.11	$0.00
March 29 2024 – April 5, 2024	0370	$0.00	$0.00
March 29 2024 – April 5, 2024	0636	$0.00	$0.00
March 29 2024 – April 5, 2024	0710	$0.00	$0.00
March 29 2024 – April 5, 2024	0730	$0.00	$0.00
March 29 2024 – April 5, 2024	0761	$0.00	$0.00
	Total	$974.11	$0.00

Requestor's Position

"Per the Addendum B- OPPS calculator the OR Service should pay $3084.03 X 200% = $5633.29. The carrier originally paid $4659.18 for the OR service. We submitted an appeal for underpayment with the Medicare allowable that shows what the markup should be. The carrier did not pay any additional amount stating, upheld, no additional allowance has been recommended."

Amount in Dispute: $974.11

Respondent's Position

"The Provider contends they are entitled to additional reimbursement for CPT code 29881. The complete services by this Provider were billed in two separate bills, the first covering the period of 03-29-2024 to 04-05-2024 (the billing for this Request for Medical Fee Dispute Resolution) and the second covering additional services for 04-05-2024 to 04-06-2024. In processing the second bill, the Carrier inadvertently overpaid for the services on that billing by $974.11. Consequently, the Carrier took credit for the overpayment against the reimbursement for the billing under this Medical Fee Dispute. The billing and Explanation of Benefits for the second date of service range is attached showing the additional reimbursement with overpayment. With the total reimbursement calculated for both billing submissions, the Provider has been properly reimbursed for the complete services under the Division's adopted fee schedule. The Carrier contends the Provider is not entitled to additional reimbursement."

Response submitted by: Travelers

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

- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.

Denial Reasons

- 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.
- 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.

- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 56 – Significant, separately identifiable E/M service rendered.
- W3 – Bill is a reconsideration or appeal
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 6494 – The billed charge was reduced to fee schedule and further reduced due to overpayment of a previous billing.
- 947 – Upheld. No additional allowance has been recommended.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in April of 2024. The insurance carrier reduced the charges based on packaging and workers;' compensation fee schedule.

   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 29881 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 0.8758 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.

2. The total recommended reimbursement for the disputed services is $5,708.42. The insurance carrier paid $5,733.36 in two payments. The first on April 26, 2024 via check 896D 98563059 in the amount of $1,074.18 and the second in the amount of $4,659.18 on May 17, 2024 via check 896D 98621148. 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 29, 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.