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

General Information

Requestor Name
Resolute Health System

Respondent Name
Standard Fire Insurance Co.

MFDR Tracking Number
M4-25-0601-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
November 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 29, 2024, through February 2, 2024	0250	$29.00	$0.00
	0278	$15,271.48	$0.00
	0300	$1,095.00	$0.00
	0360	$32,592.57	$3,973.51
	0370	$8,900.00	$0.00
	0420	$312.00	$0.00
	0424	$657.00	$0.00
	0636	$1,095.00	$0.00
	0710	$3,837.00	$0.00
	0730	$1,778.00	$0.00
	WC Adjustments (per Requestor)	($61,593.54)	$0.00
	Total	$3,973.51	$3,973.51

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Travelers, but the bill was underpaid and not paid in accordance with Chapter 134 regarding proper reimbursement for implantables. However, despite the Hospital's efforts and Request for

Reconsideration Travelers has not rendered proper payment."

Amount in Dispute: $3,973.51

Respondent's Position

"The carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated at $8,218.43 for the admission and $198.92 for the two Stryker screws documented in the operative report. The additional codes sought by the Provider are considered included in the primary procedure codes already reimbursed… 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

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 the payment for the disputed services 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.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee.
- 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.
- 5554 – Paid per invoice cost plus any applicable state markup.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.

Issues

1. Did the insurance carrier reimburse the disputed services in accordance with the applicable DWC Rule 28 TAC §134.403?
2. Which disputed code(s) are payable in accordance with DWC Rule 28 TAC §134.403 and Medicare payment policies?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement in the amount of $3,973.51 for outpatient facility charges rendered January 29, 2024, through February 2, 2024.

   Per the explanation of benefits (EOB) submitted, the insurance carrier previously issued a payment in the amount of $8,417.35 for the services in dispute.

   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) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract exists, reimbursement shall be 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 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…"

   According to a review of the submitted medical bills, DWC finds that the requestor did not request separate reimbursement for surgical implants. Therefore, the MAR for the disputed service shall be the Medicare facility specific reimbursement amount multiplied by 200 percent.

   DWC finds that the insurance carrier did not reimburse the disputed services in accordance

with DWC Rule 28 TAC §134.403.

2. On the disputed date of service, the requestor billed two surgery procedure codes, 29888 and 29883. 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 29883 is described as an arthroscopic procedure that involves surgical repair of a torn meniscus in both the medial and lateral compartments of the knee. Per Medicare Addendum J CY2024, which lists the ranks used to determine primary assignment of comprehensive HCPCS codes, code 29883 has a ranking of 1,788.

   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.

2. The requestor is seeking additional reimbursement in the amount of $3,973.51 for outpatient surgical services rendered January 29, 2024, through February 2, 2024.

   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 in accordance with the applicable fee guidelines referenced above is shown below.

   - Procedure code 29888 has status indicator J1, for outpatient comprehensive packaging.
   - This code is assigned APC 5114. The OPPS Addendum A rate is $6,816.33 multiplied by 60% for an unadjusted labor amount of $4,089.798, in turn multiplied by facility wage index 0.8791 for an adjusted labor amount of $3,595.341.
   - The non-labor portion is 40% of the APC rate, or $2,726.532.
   - The sum of the adjusted labor amount and the non-labor portion is $6,321.873.
   - Therefore, the Medicare facility specific amount is $6,321.873. This amount is multiplied by 200% for a MAR of $12,643.75.
   - A review of the EOBs submitted finds that the insurance carrier paid a total amount of $8,417.35 for the services in dispute.

- The requestor is seeking additional reimbursement in the amount of $3,973.51 per the DWC060 Request for Medical Fee Dispute Resolution (MFDR) Form submitted.
- DWC finds that the requestor is entitled to additional reimbursement in the amount of $3,973.51.

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 established that additional reimbursement in the amount of $3,973.51 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 Standard Fire Insurance Co. must remit to Resolute Health System $3,973.51 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	February 7, 2025 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.