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
M4-25-1364-01

Carrier's Austin Representative
Box Number 12

DWC Date Received
February 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 14, 2024	26785	$3216.10	$0.00
February 14, 2024	14041	$432.14	$0.00
February 14, 2024	99284	$781.10	$1,121.85
	Total	$4,429.34	$1,121.85

Requestor's Position

"After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 26715, allowed amount of $2,854.21, multiplied by 200%, CPT Code 14041, allowed amount of $216.07, multiplied by 200%, CPT Code 26785, allowed amount of $1608.05, multiplied by 200% x 0.5 and CPT Code 99284, allowed amount of $390.55, multiplied at 200% reimbursement should be $8,077.57. Payment received $3,710.47 thus, according to these calculations; there is a pending payment in the amount of $4367.10."

Amount in Dispute: $4,429.34

Respondent's Position

"The drugs, supplies, recovery, anesthesia, etc. are all included within the main procedure which is code R350/26715-F1 for the open treatment of metacarpophalangeal dislocation. The code R278

/ C1713 was denied as an invoice was not provided. When the pricing for the implantable is requested by the provider, the documentation(s) necessary for payment consideration must be verified by the client and the cost associated with each implantable code/charge must be entered for SmartAdvisor to price the implantable correctly per Rule 134.402."

Response submitted by: NorGuard

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.
- 370 - This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 617 – This item or service is not covered or payable under the Medicare Outpatient fee schedule.
- 618 – The value of the procedure is packaged into the payment of other services performed on the same date of service.
- 95 – Plan procedure not followed.
- 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.
- U00 – There was no UR procedure/treatment request received.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

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

Findings

1. The requestor submitted a DWC60 with many entries but of these on the following codes list an amount in dispute, 26785, 14041 and 99284. These codes were reduced based on APC rate and workers' compensation jurisdictional fee schedule and denied based on packaging. The rules applicable to these codes are discussed below.

   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 was not made. The facility specific reimbursement will be multiplied by 200 percent.

   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.

   - Per Medicare policy, procedure code 11012 has a status indicator of J1. However, the medical bill also contains services with status indicator J2 the applicable Medicare composite payment policy found in the Medicare Claims Processing Manual, Chapter 4, Section 10.2.1 at www.cms.gov, states, "p*ayment for all adjunctive services reported on the same claim as a J2 service is packaged into payment for the J2 service when certain conditions are met*. Based on this payment policy no payment is recommended for code 11012.
   - Per Medicare policy, procedure code 26785 has a status indicator of J1 but as seen above, due to claim qualifying for comprehensive APC, no payment is recommended.

- Procedure code 99284 has status indicator J2, for outpatient visits subject to comprehensive packaging if 8 or more hours observation billed. Review of the submitted medical bill found 19 hours of observation were submitted under cod G0378. The criteria for comprehensive observation services are met.

  This code is assigned APC 8011. The OPPS Addendum A rate is $2,610.71 multiplied by 60% for an unadjusted labor amount of $1,566.43, in turn multiplied by facility wage index 0.8758 for an adjusted labor amount of $1,371.88.

  The non-labor portion is 40% of the APC rate, or $1,044.28.

  The sum of the labor and non-labor portions is $2,416.16.

  The Medicare facility specific amount is $2,416,16, multiplied by 200% for a MAR of $4,832.32.

2. The total recommended reimbursement for the disputed services is $4,832.32. The insurance carrier paid $3,710.47. The amount due is $1,121.85. This amount 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 established that additional reimbursement 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 Norguard Insurance Co must remit to Doctors Hospital at Renaissance $1,121.85 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	March 28, 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.