



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Doctor's Hospital at Renaissance

**Respondent Name**

LM Insurance Corp

**MFDR Tracking Number**

M4-25-3003-01

**Carrier's Austin Representative**

Box Number 60

**DWC Date Received**

June 22, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
11/21/2024	N400143925010ML	\$0.00	\$0.00
11/21/2024	IV NS ADD-A-VIAL BAG	\$0.00	\$0.00
11/21/2024	DRESSING COBAN 6" X 5 YDS	\$0.00	\$0.00
11/21/2024	C1713	\$0.00	\$0.00
11/21/2024	36415	\$0.00	\$0.00
11/21/2024	80048	\$0.00	\$0.00
11/21/2024	82962	\$0.00	\$0.00
11/21/2024	85027	\$0.00	\$0.00
11/21/2024	85610	\$0.00	\$0.00
11/21/2024	85730	\$0.00	\$0.00
11/21/2024	29888	\$793.60	\$630.84
11/21/2024	29880	\$5,182.06	\$0.00
11/21/2024	ANESTHESIA GEN LEVEL	\$0.00	\$0.00
11/21/2024	J2003	\$0.00	\$0.00
11/21/2024	J2270	\$0.00	\$0.00
11/21/2024	J1100	\$0.00	\$0.00
11/21/2024	J2405	\$0.00	\$0.00
11/21/2024	J2250	\$0.00	\$0.00
11/21/2024	J2710	\$0.00	\$0.00
11/21/2024	J1885	\$0.00	\$0.00

11/21/2024	J3010	\$0.00	\$0.00
11/21/2024	J1596	\$0.00	\$0.00
11/21/2024	J0690	\$0.00	\$0.00
11/21/2024	J2704	\$0.00	\$0.00
11/21/2024	A9270	\$0.00	\$0.00
<b>Total</b>		\$5,975.12	\$630.84

### Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled "Request for reconsideration" dated April 15, 2025 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."

**Amount in Dispute:** \$5,975.12

### Respondent's Position

"This letter acknowledges receipt of your Liberty Health Care Network (HCN) complaint on 07/24/2025."

#### Supplemental response submitted July 25, 2025

"We have again reviewed payment for the services of Nov. 19-21, by DOCTORS HOSPITAL AT RENA and determined that reimbursement was issued according to the guidelines provided by the Texas Medical Fee Schedule. No additional payment is due."

**Response submitted by:** Liberty Mutual

### 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 \(TAC\) §133.305](#) sets out the procedures for resolving medical disputes.
- [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

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

- 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.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 802 – Charge for this procedure exceeds the OPPTS schedule allowance.
- 877 – Reimbursement is based on the contracted amount.
- Z547 – Any network reduction is in accordance with the Coventry owned contract. Please direct questions regarding contractual network reductions to 1-800-937-6824. This reimbursement may reflected payment at rates less than your discounted contract rate in accordance with your PPO network contract and our access agreement with them.

### Issues

1. Is the claimant enrolled in certified health network?
2. What is the rule applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

### Findings

1. The requester is seeking payment of outpatient hospital charges rendered on November 19 - 21, 2024. The insurance carrier reduced the payment amount based on contract/network reduction. Review of the submitted information and information known to the Division found insufficient evidence to support the claimant was enrolled in a certified health network. The reduction based on contracted amount is not supported and will not be considered in this review.
2. The requester listed many codes on the submitted DWC60 however, only the codes 29888 and 29880 indicate an amount in dispute. These codes will be reviewed per the applicable fee guideline. 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](http://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 exists 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; Review of the submitted documentation found no evidence of a contract and the submitted medical bill did not contain a request for separate implant reimbursement.

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 29888 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 5114. The OPPS Addendum A rate is \$6,816.33 multiplied by 60% for an unadjusted labor amount of \$4,089.80, in turn multiplied by facility wage index 0.8758 for an adjusted labor amount of \$3,581.85.

The non-labor portion is 40% of the APC rate, or \$2,726.53.

The sum of the labor and non-labor portions is \$6,308.38.

The Medicare facility specific amount is \$6,308.38 multiplied by 200% for a MAR of \$12,616.76.

- Procedure code 29880 also has a status indicator of J1. However, the applicable Medicare payment policy allows payment only on the highest ranked J1 procedure. Review of the applicable addenda J1 at [www.cms.gov](http://www.cms.gov), found code 29880 has a ranking of 1,973. Code 29888 has a ranking of 454. Code 29888 is the highest ranked J1 procedure and the only code that will receive reimbursement. Separate payment is not recommended for code 29880.

3. The total recommended reimbursement for the disputed services is \$12,616.76. The insurance carrier paid \$11,985.92. The amount due is \$630.84. 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 of \$630.84 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that LM Insurance Corp must remit to Doctors Hospital at Renaissance \$630.84 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

_____	_____	August 21, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).