TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Fort Worth

Respondent Name
TX Public School WC Project

MFDR Tracking Number
M4-18-5152-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All charges on itemized statement regarding surgery equal a total of $10,003.75 for surgery lines..."

Amount in Dispute: $16,502.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent contends that the itemized statement submitted by Requestor with its initial bill included codes, units and charges that did not match its UB-004 billing to Respondent."

Response Submitted by: Creative Risk Funding, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 13, 2017	Outpatient Hospital Services	$16,502.20	$10,215.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out billing requirements for workers compensation medical claims.
3. 28 Texas Administrative Code §133.210 sets out documentation requirements.
4. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payer deems the information submitted does not support the level of service

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- Notes: Billed charges do not match itemized charges specifically charges for revenue code 360
- 29 – The time limit for filing has expired

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered on December 13, 2017 in the amount of $16,502.20. The insurance carrier denied disputed services with claim adjustment reason codes 150 – "Payer deems the information submitted does not support this level of service" and 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication." A note of "Billed charges do not match itemized charges specifically charges for revenue code 360."

   Review of the submitted medical bill with a creation date of January 3, 2018 finds under Revenue Code 360 a total of $10,003.75. Review of the submitted itemized statement found "SVC Code 5980194, OR LV IV 1st HR for $4,365.25 and SVC Code 5980195, OR LV IV EA ADDL 30 MIN, $5,638.50." These two OR charges total $10,003.75. The carrier's "note" is not supported.

   28 Texas Administrative Code §133.10 (f) (2), (T) – (Y) states,

   > (2) The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care:
   >
   > (T) revenue codes (UB-04/field 42) are required;
   >
   > (U) revenue description (UB-04/field 43) is required;
   >
   > (V) HCPCS/Rates (UB-04/field 44):
   >
   > (i) HCPCS codes are required when billing for outpatient services and an appropriate HCPCS code exists for the service line item; and
   >
   > (ii) accommodation rates are required when a room and board revenue code is reported;
   >
   > (W) service date (UB-04/field 45) is required when billing for outpatient services;
   >
   > (X) service units (UB-04/field 46) is required;
   >
   > (Y) total charge (UB-04/field 47) is required;

   Review of the submitted UB-04 found the required elements listed above were completed. The carrier's denial for 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication" is not supported.

   28 Texas Administrative Code 133.210 (c)(2) states in pertinent part,

   > In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:
   >
   > (2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report;

   Review of the submitted "Operative Note" dated December 13, 2017 found the following performed procedures, Arthroscopic extensive debridement, Ulnar nerve decompression, Flexor tendon repair, Medial ulnar collateral ligament repair, Flexor tendon repair. The surgical procedures billed are:

   - 24345 - Repair medial collateral ligament, elbow, with local tissue

- 25260 - Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
- 29838 - Arthroscopy, elbow, surgical; debridement, extensive
- 64718 - Neuroplasty and/or transposition; ulnar nerve at elbow

The carrier's denial of 150 – "Payer deems the information submitted does not support this level of service" is not supported.

The respondent states in their position statement, "Respondent contends that the itemized statement submitted by Requestor with its initial bill included codes, units and charges that did not match its UB-004 billing to Respondent." After review of the submitted information, the Division finds the denials and position of the respondent is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.403(f)(1)

> 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.
>
> 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 finds a request for implants is not applicable. The maximum allowable reimbursement will be calculated per 28 Texas Administrative Code 134.403 (f)(1)(A) shown below.

3. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) and Status Indicator for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. The Status Indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates and Status Indicators in the OPPS final rules, available from www.cms.gov.

Reimbursement for the disputed services based on the above Medicare payment policy and Division fee guideline is as follows:

- Procedure code 24345 has status indicator J1 a comprehensive procedure code. Specifics of the Medicare payment policy for comprehensive procedure codes is found at www.cms.gov, Claims Processing Manual, Chapter Four, Section 10.2.3, and states,

  > *Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:*
  > - *lower ranked comprehensive procedure codes (status indicator J1)*

  The ranking for code 24345 is 316 the highest of all codes with J1 status indicator. This code is assigned APC 5114. The OPPS Addendum A rate is $5,221.57, multiplied by 60% for an unadjusted labor amount of $3,132.94, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $3,018.90. The non-labor portion is 40% of the APC rate, or $2,088.63. The Medicare facility specific amount of $5,107.53 is multiplied by 200% for a MAR of $10,215.06.
- Procedure code 25260 has a J1 status indicator with a ranking of 1,789 not the highest ranking comprehensive procedure code and is therefore packaged.

- Procedure code 29838 has a J1 status indicator with a ranking of 1,417 not the highest ranking comprehensive procedure code and is therefore packaged.
- Procedure code 64718 has a J1 status indicator with a ranking of 2,448 not the highest ranking comprehensive procedure code and is therefore packaged.

4. The total recommended reimbursement for the disputed services is $10,215.06. The insurance carrier paid $0.00. The amount due is $10,215.06. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $10,215.06

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $10,215.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		September 21, 2018
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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.