TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Fort Worth

Respondent Name
Twin City Fire Insurance Co

MFDR Tracking Number
M4-20-0628-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the EOB, the carrier states this code bundles into the total facility payment. They have note paid at all on this bill."

Amount in Dispute: $10,967.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our review of the disputed date of service shows that the provider would need to resubmit with a corrected billing."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2018	29806, 29827	$10,967.95	$10,967.95

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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
   - 899 – In accordance with clinical based coding edits of comprehensive surgery
   - 193 – Original payment decision is being maintained
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Is the insurance carrier's denial of disputed services supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $10,967.95 for outpatient hospital services rendered on November 29, 2018. The insurance carrier denied the disputed services based on bundling and coding edits.

   28 TAC §134.403 (d) requires Texas workers' compensation system participants to apply Medicare payment policies of coding, billing, reporting and reimbursement in effect on the date of service.

   Review of Medicare coding policy at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index finds Code 29806 does have an edit with code 29827. The denial for this code is supported.

   Review of the above found Code 29827 does not have an edit and is not bundled into any other code.

   However, the combination of Codes 29806 and 29827 was found to qualify for a complexity adjustment and the combination is designated a combined comprehensive APC ranking. The calculation based on this Medicare payment policy is discussed below.

2. 28 TAC §134.403, (f) states the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount. This amount is achieved by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors published annually in the *Federal Register.*

   When separate reimbursement for implants is not requested, the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount (if applicable) shall be multiplied by 200 percent.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.2.3.

   > ***When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family.***

   The maximum allowable reimbursement per the above is calculated as follows:

   - The combination of code 29806 and 29827 has a complexity adjustment assignment of APC 5115.
   - The OPPS Addendum A rate is $10,122.92, multiplied by 60% for an unadjusted labor amount of $6,073.75, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $5,913.40.
   - The non-labor portion is 40% of the APC rate, or $4,049.17.
   - The sum of the labor and non-labor portions is $9,962.57. The cost of services does not exceed the threshold for outlier payment.
   - The Medicare facility specific amount of $9,962.57 is multiplied by 200% for a MAR of $19,925.14.

3. The total recommended reimbursement for the disputed services is $19,925.14. The insurance carrier paid $0.00.

   The requestor is seeking additional reimbursement of $10,967.95. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $10,967.95.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $10,967.95, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 6, 2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

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