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 Rockwall

**Respondent Name**
Texas Mutual Insurance Co

**MFDR Tracking Number**
M4-20-1065-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
December 27, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This request for reconsideration of adjusted and/or disputed amounts is due to underpaid/denied APC."

**Amount in Dispute:** $321.07

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requester billed code 99283 and code 90471. The 2019 NCCI edits indicate a modifier is required for separate payment of code 99283 when billed with 90471. Review of the requestor's bill shows no modifier used with code 99283. No payment is due."

**Response Submitted by:** Texas Mutual Ins

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| March 24, 2019 | 99283 | $321.07 | $321.07 |

## *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 denied the payment for the disputed services with the following claim adjustment codes:
   - 432 – Per NCCI edits the value of this procedure is included in the value of the comprehensive procedure

**Issues**

1. Is the respondent's position 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 respondent states, "The 2019 NCCI Edits indicate a modifier is required for separate payment of code 99283 when billed with 90471."

   Review of the NCCI edits found an edit does exist however, the status indicator determines how codes are paid result in a different payment calculation.

   The payment based on 28 TAC §134.403 requires reimbursement to be based on the adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors.

   28 TAC §134.403 (d)(1) states, "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program."

   The Medicare OPPS reimbursement formula and factors are used with the DWC applicable fee guideline shown below.

2. 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.

   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.

   28 TAC §134.403, (f) states the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount multiplied by 200 percent unless a request for separate reimbursement is made. Review of the submitted medical bill finds implants are not applicable.

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

   - Procedure code 99283 has status indicator J2 when the criteria for comprehensive observation is met (8 or more hours of observation billed with emergency room visit) but as the criteria is not met, the status code is APC 5023, status indicator V.

     The OPPS Addendum A rate is $222.99, multiplied by 60% for an unadjusted labor amount of $133.79, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $130.26. The non-labor portion is 40% of the APC rate, or $89.20. The sum of the labor and non-labor portions is $219.46. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $219.46 is multiplied by 200% for a MAR of $438.92.

   - Procedure code 90471 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. No separate payment is recommended.

3. The total recommended reimbursement for the disputed services is $438.92. The insurance carrier paid $117.61. The requestor is seeking additional reimbursement of $321.07. 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 additional payment is due. The amount ordered is $321.07.

## *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 $321.07, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 23, 2020

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.**