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
USMD Hospital at Arlington

Respondent Name
West American Insurance Co

MFDR Tracking Number
M4-20-1168-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 10, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For all listed APC's, the total APC payment calculates to $899.47 x 200% = $1,798.94. The carrier only paid $620.30."

Amount in Dispute: $2,345.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Denial for 64450 states; Per NCCI, the procedure code is denied, based on standard of medical, surgical practice as procedure included in 96365."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2019	Outpatient emergency room	$2,345.15	$0.00

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 §134.430 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 903 – In accordance with clinical based coding edits… procedure (6000-69999) has been disallowed

Issues

1. Is the insurance carrier's denial of payment supported?
2. What rule is applicable to the fee calculation?

Findings

1. The requestor is seeking additional reimbursement for emergency room services rendered April 18, 2019 in the amount of $2,345.15. The insurance carrier denied based on Medicare NCCI edits.

   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.

   Review of the applicable NCCI edits finds Code 64450 has an edit with code 96365. No modifier was used to support how this was a separate and distinct procedure. The insurance carrier's denial is supported. The fee calculation of the remaining services is shown below.

2. 28 TAC §134.403, (f) states 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 200 percent; unless separate reimbursement of implants is requested.

   Review of the submitted medical bill finds implants are not applicable. The fee calculation is as follows;

   - Procedure code 96365 has status indicator S and is assigned APC 5693. The OPPS Addendum A rate is $187.18, multiplied by 60% for an unadjusted labor amount of $112.31, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $109.35. The non-labor portion is 40% of the APC rate, or $74.87. The sum of the labor and non-labor portions is $184.22. The Medicare facility specific amount of $184.22 is multiplied by 200% for a MAR of $368.44.
   - Procedure code 73130 has status indicator Q1 and is packaged into Code 96365
   - Procedure code 64450 has an NCCI edit with code 96365. Payment is not allowed
   - Procedure code 99282 is assigned APC 5022. The OPPS Addendum A rate is $127.96, multiplied by 60% for an unadjusted labor amount of $76.78, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $74.75. The non-labor portion is 40% of the APC rate, or $51.18. The sum of the labor and non-labor portions is $125.93. The Medicare facility specific amount of $125.93 is multiplied by 200% for a MAR of $251.86.
   - Procedure code 90715 has status indicator N reimbursement is included with payment for the primary services.
   - Procedure code J0690 has status indicator N reimbursement is included with payment for the primary services.
   - Procedure code 90471 has status indicator Q1 and is packaged into cod 96365l

   The total recommended reimbursement for the disputed services is $620.30. The insurance carrier paid $620.30. Additional payment is not 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 not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 31, 2020
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 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.