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**
UT Health East Texas

**Respondent Name**
Hartford Insurance Co

**MFDR Tracking Number**
M4-20-1700-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
March 9, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per Texas Fee Schedule, this bill has been underpaid."

**Amount in Dispute:** $587.36

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Dates of service in dispute were processed in accordance with Texas Workers' Compensation Guidelines, 28 TAC §134.403, §134.203 (c)."

**Response Submitted by:** The Hartford

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| November 25, 2019 | Outpatient Hospital Services | $587.36 | $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 §134.403 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:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed

- P12 – Workers' compensation jurisdictional fee schedule adjustments

**Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking additional reimbursement in the amount of $587.36 for outpatient hospital services rendered in November 2019. The insurance carrier reduced the disputed services based on workers compensation fee schedule and 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.

   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.

   Review of the submitted medical bill is reviewed based on the above as follow;

   - Procedure code 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 80053 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 85610 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 85730 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 73590 has status indicator Q1, is packaged into codes with Status Indicator S, T or V. No separate reimbursement.
   - 28 TAC 134.403 (f) states The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, 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* multiplied by 200 percent.

     Procedure code 29505 has status indicator T and is assigned APC 5101. The OPPS Addendum A rate is $134.62.

     This is multiplied by 60% for an unadjusted labor amount of $80.77, in turn multiplied by facility wage index 0.8244 for an adjusted labor amount of $66.59.

     (Please note: Medicare updates Wage Index factors every October 1st, effective for the Federal Fiscal Year – not the calendar year.)

     The non-labor portion is 40% of the APC rate, or $53.85. The sum of the labor and non-labor portions is $120.44. The Medicare facility specific amount is $120.44. This is multiplied by 200% for a MAR of $240.88.
   - Procedure code 90471 has status indicator Q1 and is packaged into status indicator S, T or V. No separate reimbursement.
   - Per Medicare National Correct Coding Initiative Edits (NCCI) at www.cms.gov, and edit exists between Code 96374 and 99291. No separate payment is recommended.
   - Per Medicare National Correct Coding Initiative Edits (NCCI) at www.cms.gov, and edit exists between Code 96375 and 99291. No separate payment is recommended.

- Procedure code 96376 has status indicator N, for packaged codes with no separate payment.
- 28 TAC 134.403 (f) states The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, 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* multiplied by 200 percent.

  Procedure code 99291 has status indicator S as the criteria for comprehensive packaging (8 or more hours observation billed) is not met. This code is assigned APC 5041. The OPPS Addendum A rate is $740.02.

  This is multiplied by 60% for an unadjusted labor amount of $444.01, in turn multiplied by facility wage index 0.8244 for an adjusted labor amount of $366.04.

  (Please note: Medicare updates Wage Index factors every October 1st, effective for the Federal Fiscal Year – not the calendar year.)

  The non-labor portion is 40% of the APC rate, or $296.01. The sum of the labor and non-labor portions is $662.05.

  The Medicare facility specific amount is $662.05. This is multiplied by 200% for a MAR of $1,324.10.
- Procedure code J2270 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2405 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is $1,564.98. The insurance carrier paid $1,564.98. 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

| Signature | Medical Fee Dispute Resolution Officer | March 31, 2020<br>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**.