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 Athens

Respondent Name
Markel Insurance Co

MFDR Tracking Number
M4-20-2946-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT Codes 99285, 96374 and 74177 have been underpaid."

Amount in Dispute: $986.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation does not support a higher level of emergency department coding for CPT code 99285."

Response Submitted by: Rising Medical Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 15, 2020	Outpatient Hospital Services	$986.51	$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 requirements for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payer deems the information submitted does not support this level of service
   - 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS
   - DDL – Documentation does not support the E/M level billed. Please resubmit with corrected coding/documentation for further review
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
- 97 – 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 payment supported?
2. What rule(s) are applicable to reimbursement?
3. Is additional reimbursement recommended?

Findings

1. The requestor is seeking reimbursement of outpatient emergency room services rendered March 15, 2020. The requestor states, "CPT Codes 99285, 96374 and 74177 has been underpaid."

   The insurance carrier denied Code 99285 based on level of service not supported by documentation. 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 description for code 99285 found, "The highest level of service, 99285 requires a comprehensive history and examination with high complexity MDM for high-severity health issues that pose an immediate threat to the life or physiologic function of the patient." Review of the submitted medical record found the injured worker walked in with a steady gait and no activation of Trauma. The "Provider Note" states – Minor Trauma (Adult) with a "Laceration Repair," then patient was discharged. The payers' denial for the level of service not being supported is upheld. No additional payment is recommended.

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 and Ambulatory Payment Category (APC).

   28 TAC 134.403 (f) states in pertinent part 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 Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register.* The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent when a separate request for implant reimbursement is not made and 108 percent when separate reimbursement for implants is made.

   The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - Procedure code 71260 has status indicator Q3, for packaged codes paid through a composite APC. The codes in the CT "family" billed by the provider were 71260, 72125, 74177 and 70450. These codes are pay under one APC of 8006. The OPPS Addendum A rate is $461.18. This is multiplied by 60% for an unadjusted labor amount of $276.71, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $267.16.
     The non-labor portion is 40% of the APC rate, or $184.47.
     The sum of the labor and non-labor portions is $451.93.
     This is multiplied by 200% for a MAR of $903.26.

   - Procedure code 96374 has status indicator S and is assigned APC 5693. The OPPS Addendum A rate is $183.74. This is multiplied by 60% for an unadjusted labor amount of $110.24, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $106.44.
     The non-labor portion is 40% of the APC rate, or $73.50.

The sum of the labor and non-labor portions is $179.94
The Medicare facility specific amount is $179.94.
This is multiplied by 200% for a MAR of $359.88.

3. The total recommended reimbursement for the allowed services is $1,412.42. The insurance carrier paid $1,412.32. 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	[redacted] Medical Fee Dispute Resolution Officer	September 14, 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.