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 Tyler

**Respondent Name**
State Office of Risk Management

**MFDR Tracking Number**
M4-20-2989-01

**Carrier's Austin Representative**
Box Number 45

**MFDR Date Received**
March 17, 2020

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This bill has been incorrectly denied based on the diagnosis code."

**Amount in Dispute:** $422.90

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Z09… is not an appropriate principle diagnosis code for this visit for treatment of a (redacted).

**Response Submitted by:** State Office of Risk Management

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| October 3, 2019 | Outpatient Hospital Services | $422.90 | $421.52 |

## *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:
    - 97 – Payment is included in the allowance for another service/procedure
    - B22 – This payment is adjusted based on the diagnosis
    - 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the status indicator determines the service is packaged or excluded from payment.

**Issues**

1. Is the insurance carrier's denial 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 $422.90 for outpatient hospital services rendered on October 3, 2019. The insurance carrier reduced the disputed services based on bundling and the diagnosis.

   The respondent states in their position, "Z09… is not an appropriate principle diagnosis code for this visit…"

   Review of the submitted medical records found the accepted diagnosis referenced by the respondent was treated initially on September 14, 2019 during an inpatient hospital stay and surgery.

   The disputed service is for the application of a cast to the affected area accepted by the insurance carrier. Insufficient evidence was found to support the denial as being global to primary procedure.

   The respondent is not denying the services based on medical necessity or compensability. The medical record supports the services were provided based on previous treatment. The service in dispute will be reviewed pre applicable fee guideline.

2. 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 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 Outpatient Prospective Payment System (OPPS) 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 29405 has status indicator T and is assigned APC 5102. The OPPS Addendum A rate is $235.58, multiplied by 60% for an unadjusted labor amount of $141.35, in turn multiplied by the facility wage index of 0.8244 for an adjusted labor amount of $116.53.

     The non-labor portion is 40% of the APC rate, or $94.23.

     The sum of the labor and non-labor portions is $210.76.

     The Medicare facility specific amount of $210.76 is multiplied by 200% for a MAR of $421.52.

3. The total recommended reimbursement for the disputed services $421.52. 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 $421.52.

## *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 $421.52, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

| Signature | Medical Fee Dispute Resolution Officer | October 9, 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**.