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**
Hartford Underwriters Insurance

**MFDR Tracking Number**
M4-21-0190-01

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

**MFDR Date Received**
October 5, 2020

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This bill has been underpaid per Texas Fee Schedule."

**Amount in Dispute:** $687.79

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The services in dispute were processed and reimbursed in accordance with the Texas Fee Schedule and 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 |
|---|---|---|---|
| June 21, 2020 | Outpatient Hospital Services | $687.79 | $329.60 |

## *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:
    - 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 payment status indicator determines the service is packaged or excluded from payment
    - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 863 – Reimbursement is based on the applicable reimbursement fee schedule
- 3411 – The sole community hospital or essential access hospital payment adjustment has been applied
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 4097 – Paid per fee schedule; charge adjusted because statute dictates allowance is greater than provider's charge
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 4097 – Paid per fee schedule; charge adjusted because statue dictates allowance is greater than provider's charge
- QBCK – The charges have been discounted per review by QMetrix's bill check service

**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 $687.79 for outpatient hospital services rendered on June 21, 2020. The insurance carrier reduced the disputed services based on bundling and workers compensation fee schedule. The reconsideration EOB indicates discount were taken per QMetrix's bill check service. Insufficient evidence was found to support a contract or written agreement exists between the requestor and this entity. The services in dispute will be reviewed per applicable fee guidelines.

   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 Q9967 has status indicator N, for packaged code reimbursement is included with payment for the primary services.
   - 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 81001 has status indicator Q4, for packaged labs reimbursement is included with payment for the primary services.
- Procedure code 83690 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 87040 has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
- Procedure code 87040-91 has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
- Procedure code 74177 has status indicator Q3 for packaged codes paid through a composite APC if another procedure in the same category is billed. Only a single service was billed. This line is assigned status indicator S and APC 5572.

  The OPPS Addendum A rate is $381.85. This is multiplied by 60% for an unadjusted labor amount of $229.11, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $221.21.

  The non-labor portion is 40% of the APC rate, or $152.74.

  The sum of the labor and non-labor portions is $373.95.

  The Medicare facility specific amount is $373.95. This is multiplied by 200% for a MAR of $747.90.
- Procedure code 96361 has status indicator S and APC 5691. The OPPS Addendum A rate is $38.11. This is multiplied by 60% for an unadjusted labor amount of $22.87, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $22.08.

  The non-labor portion is 40% of the APC rate, or $15.24.

  The sum of the labor and non-labor portions is $37.32 multiplied by 2 units is $74.64.

  The Medicare facility specific amount is $74.64. This is multiplied by 200% for a MAR of $149.28.

  The insurance carrier made no payment on this line citing fee schedule and Sole Community or Essential Access Adjustment. These non-payment reductions are not supported.
- Procedure code 96374 XU. The requestor indicates the XU modifier defined as "Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service."

  Review of the description of 96374 found, "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug." The submitted documentation does not support this procedure was distinct from the emergency room services. The XU modifier is not supported. Additionally, Code 93674 has a CCI edit with code 74177. No separate payment is recommended.
- Procedure code 96375 has status indicator S and is assigned APC 5691. The OPPS Addendum A rate is $38.11. This is multiplied by 60% for an unadjusted labor amount of $22.87, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $22.08.

  The non-labor portion is 40% of the APC rate, or $15.24.

  The sum of the labor and non-labor portions is $37.32.

  The Medicare facility specific amount is $37.32. This is multiplied by 200% for a MAR of $74.64.

  The insurance carrier made no payment on this line citing fee schedule and Sole Community or Essential Access Adjustment. These non-payment reductions are not supported.

- Procedure code 99285 has status indicator J2 for comprehensive packaging when 8 or more hours observation billed but as the criteria is not met, this code is assigned APC 5025 with a status indicator of V.

  The OPPS Addendum A rate is $504.51. This is multiplied by 60% for an unadjusted labor amount of $302.71, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $292.27.

  The non-labor portion is 40% of the APC rate, or $201.80.

  The sum of the labor and non-labor portions is $494.07.

  The Medicare facility specific amount is $494.07. This is multiplied by 200% for a MAR of $988.14.

- Procedure code J2270 has status indicator N for packaged codes reimbursement is included with payment for the primary services.

- Procedure code J2405 has status indicator N for packaged codes reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is $1,959.96. The insurance carrier paid $1,630.36. The amount due is $329.60. 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 $329.60.

## *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 $329.60, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

| Signature | Medical Fee Dispute Resolution Officer | November 5, 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**.