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
LAKE GRANBURY MED CTR

Respondent Name
OHIO SECURITY INSURANCE CO

MFDR Tracking Number
M4-21-1701-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
May 24, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "991 – Underpaid/Denied APC. The injection service (J0840) should be separately paid due to the presence of status indicator K. Please see the CMS Addendum D that details how status indicator K is paid separately under OPPS."

Amount in Dispute: 20,969.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT J0840 has a status indicator K which is paid under OPPS; separate APC payment. However, J0804 is being denied as 99285 has Status indicator J2 which has indicator 2 – see below. This is Outpatient bill and does not follow NCCI. Can't just follow language that is under K; have to consider other codes billed an review directions under those codes. In this case 99285, which states all covered Part B services on the claim is packaged with status indicator of 'F', 'G', 'H', 'L' and 'U'-'K' is not listed as exception and therefore not payable."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 26, 2020 to May 27, 2020	Outpatient Hospital Services	$20,969.40	$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:
    - 243 – The charge for this procedure was not paid since the value of this procedure is included within the value of another procedure performed
    - 4097 – Paid per Fee Schedule: charge adjusted because statue indicates allowance is greater than providers charge
    - 4915 – The charge for the services represented by the revenue code are included into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is a packaged or excluded from payment
    - 4958 – Charge for this procedure exceeds the OPPS J2 comprehensive adjustment fee schedule allowance
    - 5732 – Insurance carrier payment to the health care provider shall be according to Commission Medical Policies and Fee Guidelines in effect on the Date(s) of service(s), Health Care Providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable or the insurance carrier is relieved of the liability under Labor Code 408.024. However, pursuant to 133.250 of this Title, the health care provider may file an appeal with the Insurance Carrier if the Health Care Provider
    - 4959 – Charge for this procedure exceeds the OPPS J2 Comprehensive adjustment fee schedule allowance
    - 901 – Outlier payment has been proportional distributed to all covered OPPS services
    - 802 – Charge for this procedure exceeds the OPPS schedule allowance

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 $20,969.40 for outpatient hospital services rendered on May 26, 2020 to May 27, 2020. The insurance carrier reduced the disputed services based on fee schedule and packaging.

   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 130 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 36415, billed May 27, 2020, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 80053 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 80048, billed May 27, 2020, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 83036 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 82550 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 83735, billed May 27, 2020, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85384 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85027, billed May 27, 2020, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85730, billed May 27, 2020, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85730 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85610, billed May 27, 2020, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85610 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85610 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

- Procedure code 99285, billed May 27, 2020, has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). This code is assigned APC 8011. The OPPS Addendum A rate is $2,203.60. This is multiplied by 60% for an unadjusted labor amount of $1,322.16, in turn multiplied by facility wage index 0.9707 for an adjusted labor amount of $1,283.42. The non-labor portion is 40% of the APC rate, or $881.44. The sum of the labor and non-labor portions is $2,164.86. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $2,164.86. This is multiplied by 200% for a MAR of $4,329.72.
- Per Medicare policy, procedure code J0840 may not be reported with another code billed on this same claim. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code J0840 may not be reported with another code billed on this same claim. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- 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.
- Procedure code J2405, billed May 27, 2020, 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 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 93005 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code G0378 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 $4,329.72. The insurance carrier paid $8,293.46. 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

[redacted] Signature

[redacted] Medical Fee Dispute Resolution Officer

June 28, 2021 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.