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
Ace American Insurance Co

MFDR Tracking Number
M4-21-1918-01

Carriers' Austin Representative
Box Number 15

MFDR Date Received
June 28, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above reference patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $335.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has paid a total of $2,770.94, which is the allowable reimbursement for CPT code 23650 plus the emergency room visit. This amount is inclusive of the entire surgical procedure; all other charges are included. Therefore, no additional reimbursement is owed."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 19-20, 2021	Outpatient Hospital Services	$335.64	$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:
    - 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.

- 898 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient cod editor), component code of comprehensive surgery; integumentary system procedure (1000-9999) has been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. How is the Medicare facility specific amount calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount $335.64 for outpatient hospital services rendered in January 2021. The insurance carrier reduced the disputed services based on CCI edits, packaging and workers' compensation fee guideline.

   DWC Rule 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).

   DWC Rule 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.

2. 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 96374 - Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug has a CCI edit with several codes included on the medical claim including the emergency room visit 99285.

     The requestor included the XU modifier on the medical claim line which is defined as "XU – Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service." Review of the submitted documentation does not support that the administration of intravenous medication was an unusual or overlapping service during the treatment received. No payment is recommended.

   - Procedure code 96375 - Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug has a CCI edit with several codes included on the medical claim including the emergency room visit 99285.

     The requestor included the XU modifier on the medical claim line which is defined as "XU – Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service." Review of the submitted documentation does not support that the administration of intravenous medication was unusual or overlapping service during the treatment received. No payment is recommended.

- Procedure code 36415 has status indicator Q4 reimbursement is included with payment for the primary services.
- Procedure code 80053 has status indicator Q4 reimbursement is included with payment for the primary services.
- Procedure code 85025 has status indicator Q4 reimbursement is included with payment for the primary services.
- Procedure code 71045 has status indicator Q3 but the composite payment criteria was not met.

  This code is assigned APC 5521. The OPPS Addendum A rate is $80.90. This is multiplied by 60% for an unadjusted labor amount of $48.54, in turn multiplied by facility wage index 0.8348 for an adjusted labor amount of $40.52.

  The non-labor portion is 40% of the APC rate, or $32.36.

  The sum of the labor and non-labor portions is $72.88.

  The Medicare facility specific amount is $72.88.

  This is multiplied by 200% for a MAR of $145.76.
- Procedure code 73030, billed January 20, 2021, has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
- Procedure code 73060 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
- Procedure code 73090 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
- Procedure code 73130 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
- Procedure codes 70450, 71260, 72125, 74177, billed January 20, 2021, have status indicator Q3 for packaged codes paid as a composite.

  This composite code is APC 8006. The OPPS Addendum A rate is $435.13. This is multiplied by 60% for an unadjusted labor amount of $261.08, in turn multiplied by facility wage index 0.8348 for an adjusted labor amount of $217.95.

  The non-labor portion is 40% of the APC rate, or $174.05.

  The sum of the labor and non-labor portions is $392.00.

  The Medicare facility specific amount is $392.00.

  This is multiplied by 200% for a MAR of $784.00.
- Procedure code 12034 has status indicator T, for procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This code is paid at 100%.

  This code is assigned APC 5052. The OPPS Addendum A rate is $345.84. This is multiplied by 60% for an unadjusted labor amount of $207.50, in turn multiplied by facility wage index 0.8348 for an adjusted labor amount of $173.22.

  The non-labor portion is 40% of the APC rate, or $138.34.

  The sum of the labor and non-labor portions is $311.56.

  The Medicare facility specific amount is $311.56.

  This is multiplied by 200% for a MAR of $623.12.

- Procedure code 23650 has status indicator T, for procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This code is paid at 50%.

  This code is assigned APC 5111. The OPPS Addendum A rate is $206.19. This is multiplied by 60% for an unadjusted labor amount of $123.71, in turn multiplied by facility wage index 0.8348 for an adjusted labor amount of $103.27.

  The non-labor portion is 40% of the APC rate, or $82.48.

  The sum of the labor and non-labor portions is $185.75.

  The Medicare facility specific amount (including multiple-procedure reduction) is $92.88.

  This is multiplied by 200% for a MAR of $185.76.

- Procedure code 96376, billed January 20, 2021, has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code 99285 has status indicator V as the composite packaging criteria was not met.

  This code is assigned APC 5025. The OPPS Addendum A rate is $522.12. This is multiplied by 60% for an unadjusted labor amount of $313.27, in turn multiplied by facility wage index 0.8348 for an adjusted labor amount of $261.52.

  The non-labor portion is 40% of the APC rate, or $208.85.

  The sum of the labor and non-labor portions is $470.37.

  The Medicare facility specific amount is $470.37.

  This is multiplied by 200% for a MAR of $940.74.

- Procedure code 90714 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code 90471 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.

3. The total recommended reimbursement for the disputed services is $2,679.38. The insurance carrier paid $2,770.94. 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	July 30, 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.