

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

UT Health Athens

**Respondent Name**

Property &amp; Casualty Ins Co of Hartford

**MFDR Tracking Number**

M4-21-2321-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

August 17, 2021

### Summary of Findings

| Dates of Service | Disputed Services   | Amount in Dispute | Amount Due |
|------------------|---------------------|-------------------|------------|
| March 12, 2021   | ER visit & CT scans | \$514.09          | \$229.11   |
| <b>Total</b>     |                     | \$514.09          | \$229.11   |

### Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Corrected Rebill. Please review for payment."

**Amount in Dispute:** \$514.09

### Respondent's Position

Based on our medical audit of the documentation in response to the disputed charges for CPT 70450, we have allowed an additional \$434.47 and CPT 99284, we have allowed an additional \$79.62. As a result, we recommended an additional \$514.09 to be paid to the provider.

**Response Submitted by:** The Hartford

## Findings and Decision

### Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

### Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- PPQM – Reimbursement based on QMedtrix correction

### Issues

1. What rule applies for determining reimbursement for the disputed services?
2. Is the requester entitled to additional reimbursement?

### Findings

1. 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](http://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 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 99284 has status indicator J2 if billed with 8 or more hours observation. The criteria are not met, the APC is 5024 with a status indicator of V.

The OPPS Addendum A rate is \$363.74. This is multiplied by 60% for an unadjusted labor amount of \$218.24, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of \$210.71.

The non-labor portion is 40% of the APC rate, or \$145.50.

The sum of the labor and non-labor portions is \$356.21.

The Medicare facility specific amount is \$356.21 multiplied by 200% for a MAR of \$712.42.

- Procedure codes 72125 and 70450 have status indicator Q3 a packaged composite APC. Both lines are paid under APC 8005. The OPPS Addendum A rate is \$224.33. This is multiplied by 60% for an unadjusted labor amount of \$134.60 in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of \$129.96.

The non-labor portion is 40% of the APC rate, or \$89.73.

The sum of the labor and non-labor portions is \$219.69.

The Medicare facility specific amount is \$219.69 multiplied by 200% for a MAR of \$439.38.

2. The total recommended reimbursement for the disputed services is \$1,151.80. The insurance carrier submitted explanation of benefits that support payment in the amount of \$922.69. The amount due is \$229.11. This amount is recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of \$229.11 is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Property & Casualty Ins Co of Hartford must remit to UT Health Athens \$229.11 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

## Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
November 23, 2021

Date

## Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).