TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
UT HEALTH ATHENS

Respondent Name
TECHNOLOGY INSURANCE COMPANY I

MFDR Tracking Number
M4-22-0023-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 08, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 13, 2021	Hospital Outpatient Services	$548.15	$8.81
	Total	$548.15	$8.81

Requestor's Position

"This Request for Reconsideration of adjusted and/or disputed amounts is due to:

336 – DOS Not Paid. Bill was not paid for the fee schedule."

Amount in Dispute: $548.15

Respondent's Position

"Please see the attached EOBs. The Carrier has paid a total of $862.07 for the emergency room visit. With regard to CPT 96374 and 96375, the IV injection and IV infusion charges are not payable for cases where the patient is only treated in the emergency room. However, if the patient goes to the observation unit (Rev Code 762), then IV injection and IV hydration charges are separately payable. For the bill in dispute, the observation room charges (Rev Code 762) was not billed; and therefore, no additional reimbursement is owed for the IV injection and IV

infusion."

Response Submitted by: Downs Stanford PC

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 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 217 – The value of this procedure is included in the value of another procedure performed on this date
- 350 – Bill has been identified as a request for reconsideration or appeal
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers Compensation jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.

2. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.40, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
    - Procedure code 71045 has status indicator Q3, for conditionally packaged codes paid as a composite if OPPS criteria are met. As packaging criteria were not met, this line is separate. 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 0.9655 for an adjusted labor amount of $46.87. The non-labor portion is 40% of the APC rate, or $32.36. The sum of the labor and non-labor portions is $79.23. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $79.23. This is multiplied by 200% for a MAR of $158.46.
    - Per Medicare policy, procedure code 96374 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 96375 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 99284 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). This code is assigned APC 5024. 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 cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $356.21. This is multiplied by 200% for a MAR of $712.42
4. The total recommended reimbursement for the disputed services is $870.88. The insurance carrier paid $862.07. The amount due is $8.81. 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 $8.81 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 Technology Insurance Company must remit to UT Health Athens $8.81 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted] [redacted] [redacted]
Medical Fee Dispute Resolution Officer

October 7, 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. 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.

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 electronico CompConnection@tdi.texas.gov.