TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
UT Health Tyler

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-0107-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 21, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 22, 2021	ER and Labs	$435.45	$0.00
	Total	$435.45	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of the reconsideration that states, "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code.

Amount in Dispute: $435.45

Respondent's Position

The provider did not bill per CMS billing guidelines/NCCI edits. No payment is due.

Response Submitted by: Texas Mutual

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 [description].

Denial Reasons

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

- P12 – Workers Compensation jurisdictional fee schedule adjustment
- 236 – This billing code is note compatible with another billing code provided on the same day according to NCCI or workers compensation state regulations/fee schedule requirements
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS
- 767 – Paid per O/P FG at 200%. Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(G).

Issues

1. Is the insurance carriers' denial supported?

2. What rule applies for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional for outpatient hospital services rendered in June 2021. The insurance carrier denied billed lines based on National Correct Coding Initiatives (NCCI) edits.

   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).

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.

- Per NCCI 96374 – Initial substance therapeutic, prophylactic, or diagnostic injection has an edit against code 99284. The insurance carrier's denial is supported no payment is recommended.

- Procedure code 96375 – Additional sequential intravenous push is an add-on code. The primary code was not paid, separate payment is not recommended.

- Procedure code 73140 has status indicator Q1, for STV-packaged codes and is packaged into Code 12042.

- Procedure code 12042 has status indicator T 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 multiplied by 200% for a MAR of $623.12.

- Procedure code 99284 has status indicator J2 if the criteria for comprehensive packaging is met. The criteria is not met as eight or more hours of observation was not billed. This code is assigned APC 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 0.8348 for an adjusted labor amount of $182.19.

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

  The sum of the labor and non-labor portions is $327.69.

The Medicare facility specific amount is $327.69 multiplied by 200% for a MAR of $655.38.

- Procedure code 90715 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code 90471 has status indicator Q1 and is packaged into Code 12042.

2. The total recommended reimbursement for the disputed services is $1,278.50. The insurance carrier paid $1,286.92. Additional payment is not 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 5, 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.