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

General Information

Requestor Name
University Medical Center

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-22-1597-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
March 31, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
10/15/2021	0250	0	$0.00
10/15/2021	0272	0	$0.00
10/15/2021	0278	0	$0.00
10/15/2021	0301	0	$0.00
10/15/2021	0302	0	$0.00
10/15/2021	0305	0	$0.00
10/15/2021	0306	0	$0.00
10/15/2021	0320	0	$0.00
10/15/2021	0360	$1786.31	$0.00
10/15/2021	0370	0	$0.00
10/15/2021	0424	0	$0.00
10/15/2021	0636	0	$0.00
10/15/2021	0710	0	$0.00
10/15/2021	0730	0	$0.00
10/15/2021	0761	0	$0.00
	Total	$1786.31	$0.00

Requestor's Position

"The carrier originally paid $1863.19. We submitted an appeal for underpayment requesting an additional $2465.87 with the Medicare allowable that shows what the markup should be along

with copy of the rule 134.404 stating that only if the provider requests that implants be processed separately do they need to include the invoice. The carrier paid an additional amount of $679.96. There is a balance of $1786.31, this is the amount we are seeking for medicl dispute."

Amount in Dispute: $1786.31

Respondent's Position

"The previous review is being maintained Payment of $2542.75) and no additional allowance is recommended as the Payment adjust Factor was applies in accordance with the DWC Guidelines.

Response submitted by: TASB Risk Fund

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:

- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 350 – Bill has been identified as a request for reconsideration or appeal
- 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas markup
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 59 – Processed based on multiple or concurrent procedure rules
- 615 – Payment for this service has been reduced according to the Medicare Multiple Surgery Guidelines
- 616 – This code has a status Q APC indicator and is packaged into other APC codes

that have been identified by CMS

- 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
- 974 – This line item was reviewed using the Fair Health Charge benchmark database outpt facility nmodule based on the provider geographic area
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used ofr property and casualty only
- U03 – The bill service was reviewed by UR and authorized

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of surgical services rendered in an outpatient hospital setting in October of 2021. The insurance carrier took reductions based on the Medicare payment policies that pertain to multiple procedures.

   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 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 20680 has status indicator Q2, for T-packaged codes; reimbursement is packaged with payment for any service with status indicator T. The applicable Medicare Payment Policy is found at www.cms.gov, Claims Processing Manual, Chapter 4, Section 10.4 C states *"T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported on the same claim. When there is a claim that includes a service that is assigned status indicator T reported on the same claim as the T-packaged service, the payment for the T-packaged service is packaged into the payment for the service(s) with status indicator T and no separate payment is made for the T-packaged service. T-packaged services are assigned status indicator Q2.* No separate payment is recommended.

- Procedure code 27599 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 multiplied by 60% for an unadjusted labor amount of $123.71, in turn multiplied by facility wage index 0.8433 for an adjusted labor amount of $104.32.

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

  The sum of the labor and non-labor portions is $186.80.

  The Medicare facility specific amount (including multiple-procedure reduction) is $93.40. This is multiplied by 200% for a MAR of $186.80.

- Procedure code 64447 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 5442. The OPPS Addendum A rate is $634.59 multiplied by 60% for an unadjusted labor amount of $380.75, in turn multiplied by facility wage index 0.8433 for an adjusted labor amount of $321.09.

  The non-labor portion is 40% of the APC rate, or $253.84.

  The sum of the labor and non-labor portions is $574.93. The Medicare facility specific amount is $574.93. This is multiplied by 200% for a MAR of $1,149.86.

- Procedure code 64450 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 5442. The OPPS Addendum A rate is $634.59 multiplied by 60% for an unadjusted labor amount of $380.75, in turn multiplied by facility wage index 0.8433 for an adjusted labor

amount of $321.09.

The non-labor portion is 40% of the APC rate, or $253.84.

The sum of the labor and non-labor portions is $574.93.

The Medicare facility specific amount (including multiple-procedure reduction) is $287.47. This is multiplied by 200% for a MAR of $574.94.

- Procedure code 82947 has status indicator A, for services paid by fee schedule or payment system other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the code on the date provided. Per DWC Professional Fee Guideline, Rule §134.203(e)(1), the facility fee is based on Medicare's Clinical Laboratory fee for this code of $3.93. 125% of this amount is $4.91

2. The total recommended reimbursement for the disputed services is $1,916.51. The insurance carrier paid $2,542.75. 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	May 4, 2022 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.