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
VHS HARLINGEN HOSPITAL

Respondent Name
TASB RISK MANAGEMENT FUND

MFDR Tracking Number
M4-22-2674-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
August 22, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 23, 2021 to September 25, 2021	Hospital Outpatient Services	$2,392.64	$0.00

Requestor's Position

Requestor did not provide a position statement.

Amount in Dispute: $2,392.64

Respondent's Position

This request will be standing on the previous allowance of $2418.69, and no additional allowance is recommended as the Line 1 and line 18 denied as included services previously (217-96361, 96365 included in emergency charges) and IV hydration charges billed on Outpatient Emergency Room bills are considered in the Emergency Room E/M charge (99282 – 99285) are not paid separtately.

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

Denial Reasons

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

- 16 – Claim/Service lacks information or has submission/billing error(s)
- 205 – This charge was disallowed as additional information/definitions is required to clarify service/supply rendered

Issues

1. What is the recommended payment amount for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any outlier payments be multiplied by 200 percent for the Hospital Outpatient services in dispute. , unless a facility or surgical implant provider requests separate payment of implantables. Separate reimbursement for implants was not requested.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Per Medicare policy, procedure code 96361, billed September 24, 2021, 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 96361, billed September 25, 2021, 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 96365 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 96366, billed September 24, 2021, 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 96372, billed September 24, 2021, has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Per Medicare policy, procedure code 96375, billed September 25, 2021, 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 U0003, billed September 24, 2021, 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 $75.00. 125% of this amount is $93.75.
- Procedure code 80307 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 81001 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85027 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85379 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85384 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85670 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

- Procedure code 85730 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 86592 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 $4.27. 125% of this amount is $5.34.
- Procedure code 86703 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 86762 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 86850 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code 86900 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code 86901 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code 87340 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 87426 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 $0.00. 125% of this amount is $0.00
- Per Medicare policy, procedure code 76805 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 76819, billed September 24, 2021, 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 96361 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 0.9649 for an adjusted labor amount of $210.58. The non-labor portion is 40% of the APC rate, or $145.50. The sum of the labor and non-labor portions is $356.08. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $356.08. This is multiplied by 200% for a MAR of $712.16.
- Procedure code J0290 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J0290, billed September 24, 2021, has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J0702, billed September 24, 2021, has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J1100 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J3475 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J7050 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J7050, billed September 24, 2021, has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J7120 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J7120, billed September 24, 2021, has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J7120, billed September 25, 2021, has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

- Per Medicare policy, procedure code 59025 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 59025, billed September 24, 2021, 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 59025, billed September 25, 2001, 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.

2. The total recommended reimbursement for the disputed services is $712.16. The insurance carrier paid $1,692.92. 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

[redacted]	[redacted]	September 22, 2022
Signature	Medical Fee Dispute Resolution Officer	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.