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
TEXAS REGIONAL MEDICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-23-1489-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 11, 2022	Code 70450, 72125 and 72128	$203.42	0.00

Requestor's Position

"According to TX workers compensation fee schedule the expected reimbursement for DOS 9/11/2022 is $649.20. Please note that Outpatient services should be reimbursed at 200% of Medicare APC rate. Previous payment received totaled $445.78 leaving a balance of $203.42."

Amount in Dispute: $203.42

Respondent's Position

"CPT codes 70450, 72125, and 72128 were processed and paid per the composite APC payment methodology. Per the Medicare Claims Processing Manual, Chapter 4 for Part B Hospital, 10.2.1 – Composite APC's.

Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole,

rather than paying individually for each code.

Our position is that no payment is due."

Response Submitted by: Texas Mutual Workers' Compensation Insurance

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 Texas Administrative Code §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:

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- CAC-P12 – Workers Compensation Jurisidictional fee schedule adjustment
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- DC4 – No additional reimbursement allowed after reconsideration. For information call (888) 532-5246
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. What rule is applicable to reimbursement?

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 . The requestor is seeking additional reimbursement for date of service September 11, 2022 for the amount of $203.42. The codes in dispute are 70450, 72125 and 72128.

DWC Rule 28 TAC §134.403 (d) states: "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs."

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 (e) states: "Regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

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 is mulitplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review to the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure codes 70450, 72125 and 72128 have a status indicator of Q3, for packaged codes through a composite APC. These codes are assigned to composite APC 8005
- The OPPS Addendum A rate is $229.05 multiplied by 60% for an unadjusted labor amount of $137.43, in turn multiplied by facility index 0.9552 for an adjusted labor amount of $131.27
- The non-labor portion is 40% of the APC rate, or $91.62
- The sum of the labor and non-labor portion is $222.89
- The Medicare facility specific amount is $229.05 multiplied by 200% for a MAR of $445.78

2. The total recommended reimbursement for the disputed services is $445.78. The insurance carrier paid $445.78. 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 of $0.00 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]		May 1, 2023
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.