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
University Medical Center

Respondent Name
Berkley National Insurance Co

MFDR Tracking Number
M4-24-0769-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 26 – 28, 2023	250	$0.00	$0.00
July 26 – 28, 2023	300	$0.00	$0.00
July 26 – 28, 2023	301	$0.00	$0.00
July 26 – 28, 2023	302	$0.00	$0.00
July 26 – 28, 2023	305	$0.00	$0.00
July 26 – 28, 2023	306	$0.00	$0.00
July 26 – 28, 2023	324	$0.00	$0.00
July 26 – 28, 2023	360	$2,894.08	$0.00
July 26 – 28, 2023	370	$0.00	$0.00
July 26 – 28, 2023	636	$0.00	$0.00
July 26 – 28, 2023	710	$0.00	$0.00
July 26 – 28, 2023	730	$0.00	$0.00
July 26 – 28, 2023	761	$0.00	$0.00
	Total	$2,894.08	$0.00

Requestor's Position

"This bill is for an outpatient surgery that should pay per TDI rule 134.403. The carrier received an original bill and paid $1529.12. We then sent the bill for reconsideration due to underpayment and the carrier has denied additional reimbursement. The CPT code payable is 20680. The payment rate is $2421.55 x wage index of 0.8555 = $4423.20. The carrier paid $1529.12 leaving a balance due of $2894.08 and this is the amount of our dispute."

Amount in Dispute: $2,894.08

Respondent's Position

"The provider is seeking payment of $2,894.08 under that CPT code. It is the carrier's position that the provider is not entitled to any additional payment."

Response submitted by Flahive, Ogden & Latson

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:

- 881 – This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 785 – These items and/or services are packaged into APC rate. Therefore there is no separate APC payment.
- 176 – Modifier 27 / TC represents the technical component of services performed.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 774 – Payment disallowed. This item is an STV-packaged code that is packaged into the payment for code with status indicator S, T, or V; or a Conditional Packaging code, for which payment is packaged into a single payment for specific combinations of services.
- 222 – Charge exceeds Fee Schedule allowance.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of Revenue Code 0360, CPT Code 20680 for date of service July 28, 2023. The insurance carrier denied the claim line based on packaging.

   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).

   - Procedure code 20680 has status indicator Q2, for T-packaged codes; reimbursement is packaged with payment for any service with status indicator T. This code is paid separately only if no other service with a status indicator of T is billed.

   A review of the submitted medical bill found Code 64447 has a status indicator of T therefore, the insurance carrier's denial of Code 20680 for packaging is upheld.

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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 9, 2024 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.