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

General Information

Requestor Name
Texas Health Fort Worth

Respondent Name
Service Lloyds Insurance Co.

MFDR Tracking Number
M4-25-0978-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
January 6, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 2, 2024	0250	$0.00	$0.00
	0270	$0.00	$0.00
	0360	$3,775.11	$3,775.11
	0370	$0.00	$0.00
	0450	$0.00	$0.00
	0636 (6 lines)	$0.00	$0.00
	0710	$0.00	$0.00
	Total	$3,775.11	$3,775.11

Requestor's Position

"…this claim was underpaid by $3,775.11. Our calculations are based on the Medicare outpatient rates for CPT code 65275 which is $3,535.99 and the outpatient work comp multiplier is 200% without separate implant reimbursement… deducting the payment $3,296.87, leaves an unpaid balance due of $3,775.11."

Amount in Dispute: $3,775.11

Respondent's Position

"We are standing on our previous denial under reconsideration bill … as CPT Code 65275-RT exceeds UR authorization, UR Vendor Case ID: …., UR Vendor Review ID: …."

Response submitted by: Mitchell International, Inc.

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 (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.

Adjustment Reasons

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

- U05 – THE BILLED SERVICE EXCEEDS THE UR AMOUNT.
- J49 – THE ALLOWANCE FOR THIS LINE HAS BEEN SUMMED WITH OTHER ALLOWANCES ON THE BILL AND REDISTRIBUTED EVENLY.
- 95 – PLAN PROCEDURES NOT FOLLOWED.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3 & 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 351 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Issues

1. What procedure codes are in dispute?
2. Is the insurance carrier's reason for denial of the disputed service, based on utilization review, supported?
3. What DWC rules apply to the reimbursement of the service in dispute?
4. Is the requester entitled to additional reimbursement?

Findings

1. This medical fee dispute resolution (MFDR) request involves outpatient facility charges rendered on March 2, 2024. A review of the "Table of Disputed Services" section of the DWC060 MFDR Request form finds that the only revenue code showing a disputed amount is revenue code 0360. A review of the submitted documentation finds that revenue code 0360 corresponds to procedure code 65275-RT on the medical bill. Therefore, DWC concludes that the only procedure code in dispute is 65275, in the amount of $3,775.11.

2. The requester is seeking additional reimbursement in the amount of $3,775.11 for procedure code 65275 rendered in an outpatient facility setting on March 2, 2024. Procedure code 65275 is described as "repair of a laceration to the non-perforating cornea, with or without removing a foreign body."

   Per the submitted explanation of benefits (EOB) dated November 5, 2024, the insurance carrier issued payment for services rendered on March 2, 2024, in the total amount of $3,296.87. Per the EOB, the insurance carrier denied reimbursement for procedure code 65275 based on a utilization review, citing reason U05, "The billed service exceeds the UR amount authorized."

   When responding to a medical fee dispute, 28 TAC §133.307 (d)(2)(I), which sets out the respondent's required documentation to support a denial for lack of medical necessity, states in pertinent part, "On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: … (I) If the medical fee dispute involves medical necessity issues, the insurance carrier must attach documentation that supports an adverse determination in accordance with §19.2005 of this title (concerning General Standards of Utilization Review)."

   A review of the documentation submitted by both parties finds that the insurance carrier provided no evidence to support the denial reason that the billed services exceeded the UR amount authorized, in accordance with 28 TAC §133.307 (d)(2)(I). The requestor is therefore entitled to reimbursement for the disputed service.

3. As this MFDR request involves outpatient hospital service charges, DWC finds that 28 TAC §134.403 applies to the reimbursement of the services in this dispute.

   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 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract exists, reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   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 following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent…"

   According to a review of the submitted medical bills, DWC finds that the requestor did not bill for surgical implants. Therefore, the MAR for the disputed service shall be the Medicare facility specific reimbursement amount multiplied by 200 percent.

   DWC finds that the insurance carrier did not reimburse the disputed services in accordance with DWC Rule 28 TAC §134.403.

4. On the disputed date of service, among other procedure codes, the requestor billed the procedure code 65275, which is described as "repair of a laceration to the non-perforating cornea, with or without removing a foreign body." Per Medicare OPPS Addendum B, this code has an APC status indicator of J1, for outpatient comprehensive packaging.

   For codes designated with payment status indicator J1, a single payment is provided for the primary service, and payment for all adjunctive services reported on the same claim are packaged into the payment for the primary service.

   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 in accordance with the applicable fee guidelines referenced above is shown below.

- Procedure code 65275 has a status indicator J1, for outpatient comprehensive packaging.
- This code is assigned APC 5504. The OPPS Addendum A rate is $3,687.69 multiplied by 60% for an unadjusted labor amount of $2,212.614, in turn multiplied by facility wage index 0.9331 for an adjusted labor amount of $2,064.590.
- The non-labor portion is 40% of the APC rate, or $1,475.076.
- The sum of the adjusted labor amount and the non-labor portion is $3,539.666.
- Therefore, the Medicare facility specific amount is $3,539.666. This amount is multiplied by 200% for a MAR of $7,079.33.
- A review of the EOBs submitted finds that the insurance carrier previously paid a total amount of $3,296.87.
- The difference between the MAR and the amount previously paid is $3,782.46.
- The requestor is seeking additional reimbursement in the amount of $3,775.11 per the DWC060 Request for Medical Fee Dispute Resolution (MFDR) Form submitted.
- DWC finds that the requestor is entitled to additional reimbursement in the amount of $3,775.11.

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 that the requestor has established that additional reimbursement in the amount of $3,775.11 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Service Lloyds Insurance Co. must remit to Texas Health Fort Worth $3,775.11 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 18, 2025 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.