TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Hunt Regional Medical Center

**Respondent Name**
Sentry Casualty Co

**MFDR Tracking Number**
M4-20-2671-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
July 13, 2020

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "In this case, due to code 99282 is identified with modifier 25 the x-rays are identified as separate billable procedures."

**Amount in Dispute:** $982.40

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "We have paid this bill correctly according to the TX workers' comp fee schedule."

**Response Submitted by:** Sentry

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| November 2, 2019 | Outpatient Hospital Services | $982.40 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service included in the payment/allowance for another service/procedure that has already been adjudicated
   - 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS

- P12 – Workers' compensation jurisdictional fee schedule adjustment

**Issues**

1. Is the requestor's position supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking additional reimbursement in the amount $982.40 for outpatient hospital services rendered in November 2019. The insurance carrier reduced the disputed services based on bundling and workers compensation fee schedule.

   The requestor states in their position statement, "…code 99282 is identified with modifier 25 the x-rays are identified as separate billable procedures."

   28 TAC §134.403 (d) requires system participants to follow Medicare payment policies. 28 134.403 (b) (3) defines Medicare payment policy as reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   The "25" modifier is used to report "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

   Review of the submitted medical bill found only three services were billed Codes 99282-25, 72070 and 72100 all part of an emergency room services rendered on the same day. The requestor's position is not supported. The services in dispute will be reviewed per applicable fee guidelines.

2. As stated above the applicable fee guideline requires application of the Medicare payment policy found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   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 Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register.* The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent when a separate request for implant reimbursement is not made and 108 percent when separate reimbursement for implants is made.

   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 72070 has status indicator Q1 and is packaged into the APC 5022 with status indicator of V for code 99282. No separate payment is recommended.
   - Procedure code 72100 has status indicator Q1 and is packaged into the APC 5022 with status indicator of V for code 99282. No separate payment is recommended.
   - Procedure code 99282 has status indicator J2 when the criteria for comprehensive is met but as no observation hours were billed this code is assigned APC 5022 with a status indicator of V.

     The OPPS Addendum A rate is $127.96. This is multiplied by 60% for an unadjusted labor amount of $76.78, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $74.13.

The non-labor portion is 40% of the APC rate, or $51.18. The sum of the labor and non-labor portions is $125.31. The Medicare facility specific amount is $125.31. This is multiplied by 200% for a MAR of $250.62.

2. The total recommended reimbursement for the disputed services is $250.62. The insurance carrier paid $251.87. Additional payment is not recommended.

**Conclusion**

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

| Signature | Medical Fee Dispute Resolution Officer | July 31, 2020<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.