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

General Information

Requestor Name
Odessa Regional Hospital

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-22-0056-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
September 13, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 23, 2021	Outpatient hospital services	$442.13	$101.68
	Total	$442.13	$101.68

Requestor's Position

Requestor did not submit a position statement but send a copy of their reconsideration request that states, "Underpaid/denied APC."

Amount in Dispute: $442.13

Respondent's Position

The previous review is being maintained (payment of $1,315.70) and no additional allowance is recommended as the payment adjustor factor was applied in accordance with the DWC guidelines…"

Response Submitted by: Mitchell International

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 [description].

Denial Reasons

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

- 131 – Claim specific negotiated discount
- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup.

Issues

1. Is the insurance carriers' reduction supported?

2. What rule applies for determining reimbursement for the disputed services?

3. Is the requester entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the charges based on a stated contract. Insufficient evidence was found to support the injured worker was enrolled in a certified network or evidence of stated contract. The insurance carrier's reduction is not supported.

2. 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 (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 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 73562 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. No separate payment is recommended.

- Procedure code 96374 was denied by the insurance carrier based on Medicare's National Correct Coding Initiatives (NCCI) edits. DWC Rule §134.403 (d) requires system participants to apply Medicare payment policies in effect on the date a service is provided. Review of the applicable NCCI edit found an edit does exist between code 96374 and 99285. Submitted documentation does not support a separate and distinct service from the emergency room services. No separate payment is recommended.

- Procedure code 99285 has status indicator J2 when billed with 8 or more hours observation billed. Review of the submitted medical bill found the criteria was not met.

  This code is assigned APC 5025 with a status indicator of V.

  The OPPS Addendum A rate is $522.12. This is multiplied by 60% for an unadjusted labor amount of $313.27, in turn multiplied by facility wage index 0.9157 for an adjusted labor amount of $286.86.

  The non-labor portion is 40% of the APC rate, or $208.85.

  The sum of the labor and non-labor portions is $495.71.

  The Medicare facility specific amount is $495.71 multiplied by 200% for a MAR of $991.42.

- Procedure code J1170 has status indicator N, for packaged codes integral to the total service package with no separate payment.

- Procedure codes 70450, 72125, 72128, 72131 have status indicator Q3 which is a composite APC. All lines are included in APC 8005.

The OPPS Addendum A rate is $224.33. This is multiplied by 60% for an unadjusted labor amount of $134.60, in turn multiplied by facility wage index 0.9157 for an adjusted labor amount of $123.25.

The non-labor portion is 40% of the APC rate, or $89.73.

The sum of the labor and non-labor portions is $212.98.

The Medicare facility specific amount is $212.98 multiplied by 200% for a MAR of $425.96.

3. The total recommended reimbursement for the disputed services is $1,417.38. The insurance carrier paid $1,315.70. The amount due is $101.68. This amount is 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 established that additional reimbursement of $101.68 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. It is ordered that Service Lloyds Insurance Co must remit to Odessa Regional Hospital $101.68 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	September 30, 2021 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.