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
SCENIC MOUNTAIN MEDICAL CENTER

Respondent Name
ZURICH AMERICAN INS CO OF ILLI

MFDR Tracking Number
M4-22-0096-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 10, 2021	Hospital Outpatient Service	$190.58	$190.58
	Total	$190.58	$190.58

Requestor's Position

"This Request for Reconsideration of adjusted and/or disputed amounts is due to:

991 – Underpaid/Denied APC PLEASE REVIEW EXPECTED CALCULATION ATTACHED

The table below indicates how the claim should be calculated and the amount due (For Reason Code Description, see corresponding line number above):."

Amount in Dispute: $190.58

Respondent's Position

"We are attaching a copy of the provider's EB-04 as well as the carrier's EOBs dated June 28, 2021 and August 20, 2021. They support the carrier's position but no additional reimbursement is owed. Per the APC allowance, the provider was paid $2,473.09. No additional payment is owed because the services were being packaged per item based upon the Medical Gee [sic])

Guidelines."

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 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

Denial Reasons

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

- P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment
- 18 – Duplicate billing: Service previously paid, adjusted and paid, disallowed or denied on prior claim form or multiple billing of service(s) billed on same date of service

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall

be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 73070 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
   - Procedure code 73070 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
   - Procedure code 24605 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5112. The OPPS Addendum A rate is $1,392.35. This is multiplied by 60% for an unadjusted labor amount of $835.41, in turn multiplied by facility wage index 0.9788 for an adjusted labor amount of $817.70. The non-labor portion is 40% of the APC rate, or $556.94. The sum of the labor and non-labor portions is $1,374.64. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $1,374.64. This is multiplied by 200% for a MAR of $2,749.28.
   - Per Medicare policy, procedure code 96374 may not be reported with another code billed on this same claim. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
   - Per Medicare policy, procedure code 99284 may not be reported with another code billed on this same claim. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
   - Procedure code J3360 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
4. The total recommended reimbursement for the disputed services is $2,749.28. The insurance carrier paid $2,473.09. The requestor is seeking additional reimbursement of $190.58. 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 $190.58 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 Zurich American Ins Co of ILLI must remit to Scenic Mountain Medical Center $190.58 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	October 19, 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.