



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Vista Medical Center

Respondent Name

Old Glory Insurance Co

MFDR Tracking Number

M4-22-1055-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

February 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 7, 2021	Emergency Services	\$360.93	\$0.00
	Total	\$360.93	\$0.00

Requestor's Position

Cpt code 96374 remains underpaid.

Amount in Dispute: \$360.93

Respondent's Position

CPT 96374 is denying because of the NCCI edits and was billed with CPT 79722.

Response submitted by: Claioms Administrative Servies, 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 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:

- This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS
- 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
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or

Issues

1. What rule applies for determining reimbursement for the disputed services?
2. Is the requester entitled to additional reimbursement?

Findings

1. 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).

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 36415 has a status indicator Q4 for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 80048 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services..
- Procedure code 73560 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
- Procedure code 96374 has a CCI edit against code 99285 and code 73722, DWC Rule 134.403 (d) states in pertinent part for coding, billing reporting and reimbursement of health care covered in this section, Texas workers' compensation participants shall apply Medicare payment policies in effect on the date a service is provided. The carrier's denial is supported no additional payment is recommended.
- Procedure code 99285 has status indicator J2 when billed with outpatient observation of 8 or more hours. The criteria for comprehensive packaging not met. This code is assigned APC 5025 with a status indicator of V.

The OPPS Addendum A rate is \$522.12 multiplied by 60% for an unadjusted labor amount of \$313.27, in turn multiplied by facility wage index 0.8474 for an adjusted labor amount of \$265.46.

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

The sum of the labor and non-labor portions is \$474.31.

The Medicare facility specific amount is \$474.31 multiplied by 200% for a MAR of \$948.62.

- Procedure code 73722 has status indicator Q3, for conditionally packaged codes paid as a composite if OPPS criteria are met. As packaging criteria were not met, this line is separate.

This code is assigned APC 5573. The OPPS Addendum A rate is \$715.18 multiplied by 60% for an unadjusted labor amount of \$429.11, in turn multiplied by facility wage index

0.8474 for an adjusted labor amount of \$363.63.

The non-labor portion is 40% of the APC rate, or \$286.07.

The sum of the labor and non-labor portions is \$649.70.

The Medicare facility specific amount is \$649.70 multiplied by 200% for a MAR of \$1,299.40.

- Procedure code A9579 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J1885 has status indicator N, for packaged codes integral to the total service package with no separate payment.

2. The total recommended reimbursement for the disputed services is \$2,248.02. The insurance carrier paid \$2,248.03. Additional payment is not 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 not established that additional reimbursement 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.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 18, 2022

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 electrónico CompConnection@tdi.texas.gov.