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
M4-22-1087-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
February 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 18, 2021	Emergency Services	$630.73	$164.64

Requestor's Position

This bill has been underpaid per Texas Fee Schedule Guidelines.

Amount in Dispute: $630.73

Respondent's Position

The previous review is being maintained (Payment of $2,761.29) and no additional allowance is recommended as the Payment Adjustor Factor was applies 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 outpatient hospital services.

Denial Reasons

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

- 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.
- 134 – Claim specific negotiated discount.
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 131 – Claim specific negotiated price.
- PDC – This bill was reviewed in accordance with your Coventry Contract.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration.

Issues

1. Is the requestors denial 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 denied codes 96374-XU, 96375-XU, 96376-XU, 99291-25, 96361 as bundled into primary payment. 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.

   Review of the Medicare NCCI Manual at www.cms.gov states, "*If the sole purpose of fluid administration (e.g., saline, D5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and shall not be reported separately.*" The insurance carrier's denial is supported.

2. 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 status indicator Q4 for packaged labs; reimbursement is included with payment for the primary services.

- Procedure code 80053 has status indicator Q4 for packaged labs; reimbursement is included with payment for the primary services.

- Procedure code 85025 has status indicator Q4 for packaged labs; reimbursement is included with payment for the primary services.

- Procedure code 85610 has status indicator Q4 for packaged labs; reimbursement is included with payment for the primary services.

- Procedure code 72170 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, 70450, 71260 and 72125 and 74177 have status indicator Q3, for conditionally packaged codes paid as a composite.

  This code is assigned APC 8006. The OPPS Addendum A rate is $435.13 multiplied by 60% for an unadjusted labor amount of $261.08, in turn multiplied by facility wage index 0.9157 for an adjusted labor amount of $239.07.

  The non-labor portion is 40% of the APC rate is 174.05.

  The sum of the labor and non-labor portions is $413.12.

  The Medicare facility specific amount is $413.21 multiplied by 200% for a MAR of $826.24.

- Procedure code 96376 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.

- Procedure code 99291 has status indicator J2, when billed in conjunction with 8 or more hours observation billed. Observation comprehensive criteria not met.

  This code is assigned APC 5041. The OPPS Addendum A rate is $692.68 multiplied by 60%

for an unadjusted labor amount of $415.61, in turn multiplied by facility wage index 0.9157 for an adjusted labor amount of $380.57.

The non-labor portion is 40% of the APC rate, or $277.07.

The sum of the labor and non-labor portions is $657.64.

The Medicare facility specific amount is $657.64 multiplied by 200% for a MAR of $1,315.28.

- Procedure code J2270 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2270 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2405 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J7030 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code Q9967 has status indicator N reimbursement is included with payment for the primary services.

3. The total recommended reimbursement for the disputed services is $2,295.14. The insurance carrier paid $2,130.50. Insufficient evidence was found to support the reduction made based on Coventry contract. The amount due is $164.64. 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 $164.64 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 must remit to Odessa Regional Hospital $164.64 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	April 25, 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 electronico CompConnection@tdi.texas.gov.