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
Odessa Regional Medical Center

Respondent Name
Employers Preferred Ins Co

MFDR Tracking Number
M4-22-1421-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
March 9, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 1, 2021	Emergency Services	$816.06	$816.06
	Total	$816.06	$816.06

Requestor's Position

"Per Texas Fee Schedle, this bill has been underpaid."

Amount in Dispute: $816.06

Respondent's Position

Uphold appeal. Per Compliance bill was processed correctly. Nurse review state documentation for 99285 does not support visit code of high severity.

Response submitted by: Conduent

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 §137.100 sets out the appriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided.
3. 28 TAC §19.2003 defines retrospective review.
4. 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:

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudcation
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- P12 – Workers compensation jurisdictional fee schedule adjustment
- T13 – Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 10 months for the date of service
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is package or excluded from payent
- 5211 – Nurse audit has resulted in an adjusted reimbursement
- 5213 – Services are not payable as documentation does not support the services rendered

Issues

1. Did the carrier follow the appropriate administrative process to address the assertion of not medically necessary?

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 the payment of Code 99285 as not medically necessary.

   The division notes that 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided. Section (e) states:

   "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Retrospective review is defined in 28 TAC §19.2003 (28) as "The process of reviewing health care which has been provided to the injured employee under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary."

   DWC Rule 28 TAC §19.2015(b) titled Retrospective Review of Medical Necessity states: (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers)."

   The division finds that the carrier failed to follow the appropriate administrative process in issuing an adverse determination based on nurse review.

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).

   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 73630 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 96372 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicaot S, T or V.

- Procedure code 99285 has status indicator J2, when billed in conjunction with 8 or more hours observation billed. The criteria for comprehensive observation is not met. This code is assigned APC 5025 with a status indicator of V.

  The OPPS Addendum A rate is $522.12. his is multiplied by 60% for an unadjusted labor amount of $313.27, in turn multiplied by facility wage index 0.8795 for an adjusted labor amount of $275.52.

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

  The sum of the labor and non-labor portions is $484.37.

  The Medicare facility specific amount is $484.37 multiplied by 200% for a MAR of $968.74.

- Procedure code J2270 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 $968.74. The insurance carrier paid $150.10. The requestor is seeking additional reimbursement of $816.06. 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 $816.06 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 Employers Preferred Ins Co must remit to Odessa Regional Medical Center $816.06 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	May 11, 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.