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
Monroe Guaranty Insurance Company

MFDR Tracking Number
M4-22-1871-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
April 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 15, 2021	Outpatient Procedure	$1,701.78	$950.66
	Total	$1,701.78	$950.66

Requestor's Position

"This bill denied for timely filing. Timely filing date for initial bill was 12/19/21. Jopari shows submission date of 12/17/21. Previous attempts noted: 9/27/21, 11/22/21, 12/17/21 and 12/29/21 (after payer denied confirmation receipt).

Amount in Dispute: $1,701.78

Respondent's Position

The Austin carrier representative for Monroe Guaranty Insurance Company is JT Parker and Associates. The representative was notified of this medical fee dispute on May 3, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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:

- 18 – Duplicate billing. Services previously paid, adjusted and paid, disallowed, or denied on prior claim for or multiple billing service(s) billed on same date of service.

Issues

1. Did the insurance carrier support denial?
2. What rule applies for determining reimbursement for the disputed services?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered in September 2021. Review of the submitted documentation found an explanation of benefits that denied the disputed service as duplicate. Insufficient evidence was found to support any other adjudication of the disputed services. The insurance carrier's denial is not supported. The applicable DWC fee guideline and Medicare payment policies are detailed below.
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 73130 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.

- Per Medicare NCCI edits, procedure code 96365 has an unbundle relationship with code 99285. No separate payment is recommended.

- Per Medicare NCCI edits, procedure code 96367 is an add-on code. The primary code 96365 has a NCCI edit with code 99285. No separate payment is recommended.

- Per Medicare NCCI edits, procedure code 96375 is an add-on code. The primary code 96365 has a NCCI edit with code 99285. No separate payment is recommended.

- Procedure code 99285 has status indicator J2 when billed in combination with eight or more hours of observation. When no observation is rendered, this code is assigned APC 5025 and has a status indicator of V.

  The OPPS Addendum A rate is $533.27 multiplied by 60% for an unadjusted labor amount of $319.96, in turn multiplied by facility wage index 0.8189 for an adjusted labor amount of $262.02.

  The non-labor portion is 40% of the APC rate, or $213.31.

  The sum of the labor and non-labor portions is $475.33.

  The Medicare facility specific amount is $475.33 multiplied by 200% for a MAR of $950.66.

- Procedure code 90715 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 90471 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.

2. The total recommended reimbursement for the disputed services is $950.66. The insurance carrier paid $0.00. The amount due is $950.66. 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 $950.66 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 respondent must remit to requestor $950.66 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	June 28, 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.