Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Frisco Medical Center

Respondent Name
Travelers Casualty & Surety Co

MFDR Tracking Number
M4-22-2293-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
June 22, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 20, 2021	72220	$157.99	$0.00
September 20, 2021	96372	$121.02	$0.00
	Total	$279.01	$0.00

Requestor's Position

"Upon review of the payment, we have found this claim to be underpaid. Per the applicable FY, we show a higher allowable. …Per CMS, Status Indicators of Q1 are conditionally packaged services. Q1 services are packaged when they appear on the same claim with services with a status indicator of S, T or V. If the Q1 service does not meet the packaging criteria, it is separately paid."

Amount in Dispute: $279.01

Respondent's Position

"The Provider alleges they are entitled to reimbursement for CPT codes 72220 and 96372. The Carrier has reviewed the documentation and contends the Provider has been reimbursed for CPT code 72100. This CPT code is the highest value Q1 code billed, and the Q1 codes are included in

that reimbursement. The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated."

Response submitted by: Travelers

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 – Payment adjusted because 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
- 96 – Non-covered charge(s)

Issues

1. Is the requestor's position supported?
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 additional reimbursement for Codes 72220 and 96372 stating these codes should be separately payable.

   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 10.4.1 and states in pertinent part, "*Where a claim contains multiple codes that are STV-packaged codes and does not contain a procedure with status indicator S, T, or V on the same claim, separate payment is made for the STV-packaged code that is assigned to the highest paid APC and payment for the other STV-packaged codes on the claim is packaged into the payment for the highest paid STV-packaged code.*" The requestor's position is not supported and the services in dispute will be reviewed per applicable fee guideline.

2. The applicable DWC fee guideline is set out in DWC Rule 28 TAC 134.403 (e) and states in pertinent part, regardless of billed amount, when no specific fee schedule or contract reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   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 72100 has a status indicator Q1 and APC of 5522. This code is the highest paid STV-packaged code and receives the reimbursement on the claim.

     The OPPS Addendum A rate is $108.97 multiplied by 60 for an unadjusted labor amount of $65.38, in turn multiplied by facility wage iondex 0.9655 for an adjusted labor amount of 63.12.

     The non-labor portion is 40% of the APC rate, or $43.39.

     The sum of the labor and non-labor portion is $106.71.

     The Medicare facility specific amount is $106.71 multiplied by 200% for a MAR of $213.42.

   - Procedure code 72220 has status indicator Q1, for STV-packaged codes; reimbursement is packaged into highest paid STV packaged code.

   - Procedure code 96372 has status indicator Q1, for STV-packaged codes; reimbursement is packaged into highest paid STV packaged code..

3. The total recommended reimbursement for the disputed services is $213.42. The insurance carrier paid $212.82. 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	July 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.