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
CRESCENT MEDICAL CENTER

Respondent Name
STARSTONE NATIONAL INSURANCE

MFDR Tracking Number
M4-22-2536-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
August 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 14, 2021	Codes 99284-25, 96372, 73030, J1885 and J2930	$1,750.00	$470.38

Requestor's Position

The APC Medicare rate is $355.18. 200% of Medicare's allowed is $710.36. (underpayment $468.32)

The actual allowed was $242.04

Amount in Dispute: $1,750.00

Respondent's Position

Please see the EOBs included in with Requestor's DWC-60. The Carrier has paid a total of $242.04. Other billed charges were denied as the submitted report did not substantiate the service being billed. Additionally, this claim is not a WC network claim.

In conclusion, Requestor is not owed any additional reimbursement for the outpatient visit as the services were not properly documented.

Response Submitted by: Downs Stanford PC

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 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 18 – Exact duplicate claim/service
- 247 – A payment or denial has already been recommended for this service
- D1 – Duplicate control number 335491
- TXP12 – Workers Compensation Jurisdiction Fee Schedule adjustment
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 275 – The charge was disallowed; as the submitted report does not substantiate the service being billed
- 4915 – The charge for the services represented by the code is included /bundled into the total facility payment
- 5880 – A more appropriate level was indicated per the records and resources require for the presenting problem per ACEP ED Level Guidelines
- 5880 – A corrected claim is needed with the correct code, units and charge for reconsideration
- 6766- Specialty Bill Audit/Expert Code Review involving the application of code auditing rules and edits based on coding conventions defined in the
- TX150 – Payment adjusted because the payer deems the information submitted does not support this level of

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for disputed service code 99284 with claim adjustment reason code 275 – "The charge was disallowed; as the submitted report does not substantiate the service being billed.".

   28 Texas Administrative Code §134.403(b)(3) states "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.403 (d) states "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs."

   The description code for 99284 is "Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function."

   Review of the submitted medical documentation supports the service billed. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any outlier payments be multiplied by 200 percent for the Hospital Outpatient services in dispute, unless a facility or surgical implant provider requests separate payment of implantables. Separate reimbursement for implants was not requested.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 96372 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.

- Procedure code 73030 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code 99284 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). This code is assigned APC 5024. The OPPS Addendum A rate is $363.74. This is multiplied by 60% for an unadjusted labor amount of $218.24, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $210.71. The non-labor portion is 40% of the APC rate, or $145.50. The sum of the labor and non-labor portions is $356.21. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $356.21. This is multiplied by 200% for a MAR of $712.42.
- Procedure code J1885 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 J2930 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.

3. The total recommended reimbursement for the disputed services is $712.42. The insurance carrier paid $242.04. The amount due is $470.38. 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 $470.38 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 STARSTONE NATIONAL INSURANCE must remit to CRESCENT MEDICAL CENTER $470.38 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted]

Signature

[redacted]

Medical Fee Dispute Resolution Officer

October 27, 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.