TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Odessa Regional Medical Center

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-23-0702-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 11, 2022	Emergency Visit	$344.41	$344.41
	Total	$344.41	$344.41

Requestor's Position

"The bill remains underpaid after appeal. CPT code 96374 has not been paid."

Amount in Dispute: $344.41

Respondent's Position

"This request will be standing on the previous allowance of $1,414.36, and no additional allowance is recommended as this was paid at the correct markiup for outpatient facility services."

Response submitted by: TASB Risk Fund

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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 217 – The value of this procedure is included in the value of another procedure performed on this date
- 370 – This hospital outpatient allowance was calculated accordiong to the APC rate, plus a markup
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 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

Issues

1. What rule applies for determining reimbursement for the disputed services?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered in March 2022. The insurance carrier reduced the charges based on bundling and the workers' compensation fee schedule.

   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 (e) 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 73030 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.

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- Procedure code 73562 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 23650 has status indicator T and is assigned APC 5111. The OPPS Addendum A rate is $210.50 multiplied by 60% for an unadjusted labor amount of $126.30, in turn multiplied by facility wage index 0.8759 for an adjusted labor amount of $110.63.

  The non-labor portion is 40% of the APC rate, or $84.20.

  The sum of the labor and non-labor portions is $194.83.

  The Medicare facility specific amount is $194.83. This is multiplied by 200% for a MAR of $389.66.

- Procedure code 96374 has status indicator S and is assigned APC 5693. The OPPS Addendum A rate is $208.93 multiplied by 60% for an unadjusted labor amount of $125.36, in turn multiplied by facility wage index 0.8759 for an adjusted labor amount

of $109.80.

The non-labor portion is 40% of the APC rate, or $83.57.

The sum of the labor and non-labor portions is $193.37.

The Medicare facility specific amount is $193.37 multiplied by 200% for a MAR of $386.74.

- Procedure code 99285 has status indicator J2 when submitted with 8 or more hours observation billed. Review of the submitted medical bill found the criteria for comprehensive obseration was not met. This code has a status indicator ov V and is assigned APC 5025.

  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 0.8759 for an adjusted labor amount of $280.25.

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

  The sum of the labor and non-labor portions is $493.56.

  The Medicare facility specific amount is $493.56 multiplied by 200% for a MAR of $987.12.

- Procedure code J1170 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 $1,763.52. The insurance carrier paid $1,414.36. The requestor is seeking additional reimbursement of $344.41. 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 $344.41 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 TASB Risk Management Fund must remit to Odessa Regional Medical Center $344.41 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	December 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.