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
Metroplex Adventist Hospital

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-23-1018-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
January 4, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 5, 2022	73610	$165.22	$2.86
July 5,2022	73600	$165.22	$0.00
	Total	$330.44	$2.86

Requestor's Position

The requestor did not submit a position statement for the disputed services but did submit a copy of their reconsideration that states, "Please review for Reconsideration and Payment. Q1 Codes are packaged with STV Codes. There was a payment made in the amount of $159.82. This leaves an underpayment of $286.10"

Amount in Dispute: $330.44

Respondent's Position

"Based on the Medicare edits, when more than one Q1 code is billed, reimbursement is issued for the Q1 code with the highest APC rate and all other Q1 codes are included in that reimbursement. Here, CPt code 73610 is the highest APC rate Q1 code. It was properly reimbursed and the other

Q1 codes are included in that reimbursement."

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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 -Bill is a reconsideration or appeal
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

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 emergency room services rendered in July 2022. The insurance carrier denied the disputed charges as packaged service.

   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 73610, 73620 and 73600 each have a status indicator Q1 (STV – package,)

  The Medicare Claims Processing Manual,Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS, Section 10.4.1 - Combinations of Packaged Services of Different Types That are Furnished on the Same Claim states, "*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*." Each of the disputed codes are assigned to APC 5521. Based on the above only one of the claims submitted on the medical bill is eligible for reimbursement. The maximum allowable reimbursement is calculated below.

- The applicable APC is 5521. The OPPS Addendum A rate is $82.61 multiplied by 60% for an unadjusted labor amount of $49.57, in turn multiplied by facility wage index 0.9744 for an adjusted labor amount of $48.30.

  The non-labor portion is 40% of the APC rate, or $33.04.

  The sum of the labor and non-labor portions is $81.34.

  The Medicare facility specific amount is $81.34 multiplied by 200% for a MAR of $162.68.

2. The total recommended reimbursement for the disputed services is $162.68. The insurance carrier paid $159.82. An additional payment of $2.86 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 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 $2.86 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	January 23, 2023 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.