Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Midland Memorial Hospital

Respondent Name
Sentry Casualty Co

MFDR Tracking Number
M4-23-3290-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 28, 2022	Emergency Visit	$514.97	$0.00
	Total	$514.97	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR) but did submit a copy of their reconsideration that states, "This Request for Reconsideration of adjusted and/or disputed amounts is due to: 991 – Underpaid/Denied APC."

Amount in Dispute: $514.97

Respondent's Position

"…please see the codes below in which provider expected payment, but were denied per TX fee schedule. CPT 96361 and 96375 denied as an addon code not billed with a parent code. CPT 96374 denied per NCCI edits as it conflicts with CPT 74177; a modifier may be appended if appropriate, but we have not received a corrected bill with a modifier added."

Response submitted by Sentry

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 the payment for the disputed services with the following claim adjustment codes:

- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying service/procedure has not been received/adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 618 – This item or service is not covered or payable under the Medicare outpatient fee schedule.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 616 – This code has a status Q APC and is packaged into other APC codes that have been identified by CMS.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 446 – This add-on code has been denied as the principal procedure was not billed.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.

Issues

1. What rule is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of emergency room services rendered in an outpatient hospital setting on October 28, 2022. The insurance carrier denied the services in dispute based on packaging and Medicare National Correct Coding Initiative (NCCI) edits.

   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 72170 has a status indicator of Q1 – STV packaged codes. Reimbursement is included with payment for service assigned status indicator S, T, or V. No payment recommended.

   - Procedure code 71045 has status indicator Q3 but as no other chest x-rays were provided this code is separately payable.

     This code is assigned APC 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 0.8382 for an adjusted labor amount of $41.55.

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

     The sum of the labor and non-labor portions is $74.59.

     The Medicare facility specific amount is $74.59 multiplied by 200% for a MAR of $149.18.

- Procedure code 74177 has status indicator Q3 but as no other CT scans were performed this code is separately payable.

  This code is assigned APC 5572. The OPPS Addendum A rate is $376.09 multiplied by 60% for an unadjusted labor amount of $225.65, in turn multiplied by facility wage index 0.8382 for an adjusted labor amount of $189.14.

  The non-labor portion is 40% of the APC rate, or $150.44.

  The sum of the labor and non-labor portions is $339.58.

  The Medicare facility specific amount is $339.58 multiplied by 200% for a MAR of $679.16.

- Procedure code 96361 is an addon code per www.cms.gov to code 96374 which has a CCI edit with code 74177. Addon codes are only payable when primary code is paid. Separate payment is not recommended.

- Procedure code 96374 has a CCI edit with code 74177. No payment is recommended.

- Procedure code 96375 is an addon code per www.cms.gov to code 96374 which has a CCI edit with code 74177. Addon codes are only payable when primary code is paid. Separate payment is not recommended.

- Procedure code 96376 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 99285 has status indicator V.

  This code 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 0.8382 for an adjusted labor amount of $268.19.

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

  The sum of the labor and non-labor portions is $481.50.

  The Medicare facility specific amount is $481.50 multiplied by 200% for a MAR of $963.00.

- Procedure code J0780 has status indicator N, for packaged codes integral to the total service package with no separate payment.

- Procedure code J3010 has status indicator N, for packaged codes integral to the total service package with no separate payment.

- Procedure code Q9967 has status indicator N, for packaged codes integral to the total service package with no separate payment.

- Procedure code 93005 has a status indicator of Q1 and is packaged into Code 99285. Separate payment is not recommended.

2. The total recommended reimbursement for the disputed services is $1,791.34. The insurance carrier paid $1,791.34. 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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 13, 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.