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
Memorial Hermann Southeast

Respondent Name
Arch Indemnity Insurance Co

MFDR Tracking Number
M4-21-2283-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 11, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 23, 2021	Outpatient X-Ray	$977.00	$0.00
September 23, 2021	Outpatient CT Scan	$3,343.00	$0.00
September 23, 2021	Outpatient CT Scan	$3,744.00	$0.00
September 23, 2021	Outpatient ER Visit	942.50	$0.00
	Total	$9006.50	$0.00

Requestor's Position

This is a bill for services provided by Memorial Hermann Hospital for a workers comp injury for the above name patient. As of right now, the claim is unreported and the carrier/employer has refused to set up a Workers Compensation claim or accept the medical record as a First Report of a claim per Texas Labor Code 124.1 (a)(3).

Amount in Dispute: $9006.50

Respondent's Position

The provider is not entitled to reimbursement of more than $874.22 which is the amount that the carrier has already reimbursed the provider.

Response Submitted by: Flahive, Ogden & Latson

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:

- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 4960 – Charge for this procedure exceeds the OPPS Q3 composite adjustment fee schedule allowance
- 56 – Significant, separately identifiable E/M service rendered

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

1. 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).

   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 73080, billed March 23, 2021, 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 99282, billed March 23, 2021, would have a status indicator of J2 if 8 or more hours observation billed but this medical bill did not contain observation the J2 criteria is not met.

  This code is assigned APC 5022 with status indicator of V. The OPPS Addendum A rate is $131.59. This is multiplied by 60% for an unadjusted labor amount of $78.95, in turn multiplied by facility wage index 1.0021 for an adjusted labor amount of $79.12.

  The non-labor portion is 40% of the APC rate, or $52.64.

  The sum of the labor and non-labor portions is $131.76.

  The Medicare facility specific amount is $131.76 multiplied by 200% for a MAR of $263.52.

- Procedure codes 70450 and 72125 have status indicator Q3, for packaged codes paid through a composite APC and are assigned status indicator S and assigned APC 8005. The OPPS Addendum A rate is $224.33. This is multiplied by 60% for an unadjusted labor amount of $134.60, in turn multiplied by facility wage index 1.0021 for an adjusted labor amount of $134.88.

  The non-labor portion is 40% of the APC rate, or $89.73.

  The sum of the labor and non-labor portions is $224.61.

  The Medicare facility specific amount is $224.61 multiplied by 200% for a MAR of $449.22.

2. The total recommended reimbursement for the disputed services is $712.74. The insurance carrier paid $874.22. 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	September 17, 2021 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.