

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

MHHS Northeast Hospital

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-22-0006-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 26, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 4, 2021	Pharmacy	\$2.00	\$0.00
January 4, 2021	X-ray	\$892.25	\$0.00
January 4, 2021	Emergency Room	\$726.50	\$0.00
January 4, 2021	Emergency Room	\$159.25	\$0.00
January 4, 2021	Emergency Room	\$2892.50	\$704.40
January 4, 2021	Drugs	\$276.00	\$0.00
January 4, 2021	Drugs	\$15.00	\$0.00
	Total	\$4,963.50	\$704.40

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 records as a First Report of a claim per Texas Labor Code 124.1 (a)(3).

Amount in Dispute: \$4,963.50

Respondent's Position

The Austin carrier representative for AIU Insurance Co is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on September 8, 2021.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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

Neither party submitted an explanation of benefits supporting adjudication of the disputed claim.

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 73130 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 12001 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 90471 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 99284 has status indicator J2 comprehensive packaging if 8 or more hours observation billed. Comprehensive packaging criteria not met. This code is assigned APC 5024 with a status indicator of V.

The OPPS Addendum A rate is \$351.79. This is multiplied by 60% for an unadjusted labor amount of \$211.07, in turn multiplied by facility wage index 1.0011 for an adjusted labor amount of \$211.30.

The non-labor portion is 40% of the APC rate, or \$140.72.

The sum of the labor and non-labor portions is \$352.02.

The Medicare facility specific amount is \$352.02 multiplied by 200% for a MAR of \$704.04.

- Procedure code 90715 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J2001 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 \$704.04. The insurance carrier paid \$0.00. The amount due is \$704.04. 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 \$704.04 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 AIU Insurance Co must remit to MHHS Northeast Hospital \$704.04 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	r _____	January 21, 2022
Signature	Medical Fee Dispute Resolution Officer	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 electrónico CompConnection@tdi.texas.gov.