

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

MHHS Northeast Hospital

**Respondent Name**

AIU Insurance Co

**MFDR Tracking Number**

M4-22-0007-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

August 24, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 1, 20021	Pharmacy	\$1.00	\$0.00
June 1, 20021	X-Ray	\$989.50	\$0.00
June 1, 20021	ER Visit	\$1508.75	\$1,009.68
	Total	\$2,499.25	\$1,009.68

### Requestor's Position

This is a bill for services provided by Memorial Hermann Hospital for a workers comp injury for the above named 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:** \$2,498.25

### Respondent's Position

The Austin carrier representative for AIU Insurance Co is Flahive, Ogden and 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 with reasons supporting adjudication of r the disputed services.

### 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](http://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 73020 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 99285 has status indicator J2 when billed with 8 or more hours observation the criteria for comprehensive observation not met.

This code is assigned APC 5025 and status indicator V. The OPPS Addendum A rate is \$504.51.

This is multiplied by 60% for an unadjusted labor amount of \$302.71, in turn multiplied by facility wage index 1.0011 for an adjusted labor amount of \$303.04.

The non-labor portion is 40% of the APC rate, or \$201.80.

The sum of the labor and non-labor portions is \$504.84.

The Medicare facility specific amount is \$504.84 multiplied by 200% for a MAR of \$1,009.68.

2. The total recommended reimbursement for the disputed services is \$1,009.68. The insurance carrier paid \$0.00. The amount due is \$1,009.68. 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 \$1,009.68 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 \$1,009.68 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 24, 2022  
\_\_\_\_\_  
Date

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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).