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
USMD Hospital at Arlington

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-22-2166-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 9, 2021	Emergency Room	$698.25	$0.00
	Total	$698.25	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $698.25

Respondent's Position

The carrier reevaluated it's position. It is issuing payment in the amount of $299.26 plus interest."

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
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – Bill is a reconsideration or appeal
- 29 – The time limit for filing claim/bill has expired

Issues

1. Was the insurance carrier's denial upheld?

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

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of emergency room services rendered in December 2021. The insurance carrier's denial based on timely filing was not upheld and the insurance carrier paid $299.26 via electronic funds transfer on June 9, 2022. The requestor did not withdraw the request for MFDR. The disputed service will be reviewed per applicable fee guidelilne.
2. 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 implants.

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 73660 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 packaged into Code 99281 which has a status indicator of V.

- Procedure code 99281 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). However review of the submitted medical bill finds the criteria for comprehensive packaging is not met.

  This code is assigned APC 5021 with a status indicator of V. The OPPS Addendum A rate is $74.08 multiplied by 60% for an unadjusted labor amount of $44.45, in turn multiplied by facility wage index 0.9579 for an adjusted labor amount of $42.58.

  The non-labor portion is 40% of the APC rate, or $29.63.

  The sum of the labor and non-labor portions is $72.21.

  The Medicare facility specific amount is $72.21 multiplied by 200% for a MAR of $144.42.

2. The total recommended reimbursement for the disputed services is $144.42. The insurance carrier paid $299.26. 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

		September 12, 2021
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 electronico CompConnection@tdi.texas.gov.