

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

VHS Harlingen Hospital

**Respondent Name**

Texas Municipal League Intergovernmental

**MFDR Tracking Number**

M4-23-0059-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

September 6, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 4, 2022	250	765.00	\$0.00
February 4, 2022	300/U003	424.00	\$0.00
February 4, 2022	300/80048	730.00	\$0.00
February 4, 2022	300/85027	404.00	\$0.00
February 4, 2022	300/49653	29445.00	\$0.00
February 4, 2022	370	5903.00	\$0.00
February 4, 2022	636/J0171	260.00	\$0.00
February 4, 2022	636/J0690	170.00	\$0.00
February 4, 2022	636/J1100	60.00	\$0.00
February 4, 2022	636/1170	88.00	\$0.00
February 4, 2022	636/J1741	312.00	\$0.00
February 4, 2022	636/J2250	42.00	\$0.00
February 4, 2022	636/J2405	56.00	\$0.00
February 4, 2022	636/J2704	640.00	\$0.00
February 4, 2022	636/J3010	74.00	\$0.00
February 4, 2022	636/J7030	329.00	\$0.00
February 4, 2022	636/J7050	396.00	\$0.00
February 4, 2022	636/J7120	654.00	\$0.00
February 4, 2022	710	10731.00	\$0.00
February 4, 2022	730/93005	1154.00	\$0.00

	Total	52643.00	\$0.00
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### **Requestor's Position**

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "Every effort is made at the time of service to obtain complete and accurate insurance information from your member in order to submit the claim in a timely manner and collect payment for the above reference services. Occasionally circumstances beyond the control of our organization occur and in this case, initial claim was set to TMI, at address 2200 Aldrich Street Austin, TX on 2/18/22. ...Claim was then sent on 4/4/22... claim was sent on 6/16/22."

**Amount in Dispute:** \$52643.00

### **Respondent's Position**

"The carrier has reprocessed the provider's bill. We are attaching a copy of the EOB dated September 14, 2022. It recommends reimbursement of \$9,834.56."

**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:

- 350 – Bill has been identified as a request for reconsideration or appeal
- 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas markup
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service

- A68 – Per DWC-MDR-Respondent owes the requestor additional reimbursement plus accrued interest per DWC Rule 134.30
- P12 – Workers’ compensation jurisdictional fee schedule adjustment

### Issues

1. What rule applies for determining reimbursement for the disputed services?
2. Is the requester entitled to additional reimbursement?

### Findings

1. The requestor is seeking payment of outpatient hospital services rendered in February of 2022. The insurance carrier submitted evidence the claim was been reprocessed and paid with interest but, the requestor did not withdraw the request for medical fee dispute resolution. The disputed charges will be reviewed per applicable fee guidelines.
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](http://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 implantables.

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 U0003, billed February 3, 2022, is included with comprehensive rate of J2 procedure.
- Procedure code 80048, billed February 3, 2022, has status indicator Q4 reimbursement is included with payment for the primary services.

- Procedure code 85027, billed February 3, 2022, has status indicator Q4 reimbursement is included with payment for the primary services.
- Procedure code 49653 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure.

This code is assigned APC 5361. The OPPS Addendum A rate is \$5,167.69 multiplied by 60% for an unadjusted labor amount of \$3,100.61, in turn multiplied by facility wage index 0.8542 for an adjusted labor amount of \$2,648.54.

The non-labor portion is 40% of the APC rate, or \$2,067.08.

The sum of the labor and non-labor portions is \$4,715.62.

The Medicare facility specific amount is \$4,715.62. This is multiplied by 200% for a MAR of \$9,431.24.

- Procedure code J0171 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J0690 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J1100 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J1170 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J1741 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2250 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2405 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2704 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J3010 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J7030 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J7050 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J7120 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code 93005, billed February 3, 2022, has status indicator Q1 and is packaged into comprehensive J1 procedure.

The total recommended reimbursement for the disputed services is \$9,431.24. The insurance carrier paid \$9,834.56. 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	January 26, 2023 Date
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## **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](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).