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**
Northeast Baptist Hospital

**Respondent Name**
Starr Indemnity & Liability Co

**MFDR Tracking Number**
M4-23-0164-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
September 20, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| September 23, 2021 | RC300 | $1565.00 | $0.00 |
| September 24, 2021 | RC300 | $50.00 | $0.00 |
| | RC250 | $4193.00 | $0.00 |
| | RC278 | $6773.00 | $0.00 |
| | RC360 | $16317.00 | $5783.88 |
| | RC370 | $3241.00 | $0.00 |
| | RC710 | 8347.00 | $0.00 |
| | WORK COMP ADJUSTMENT | -34702.12 | |
| | **Total** | $5783.88 | $5783.88 |

## Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed ESIS, but the bill was underpaid. The Hospital requested ESIS review denial and issue payment. However, despite the Hospital's efforts and Request for Reconsideration, ESIS has not issued payment."

**Amount in Dispute:** $5783.88

## Respondent's Position

"In reviewing the file as well as the response filed on 10-12-22 the correct amount of the payment issued is $5,783.88.  The check was actually reissued on 10-13-22 as there was no record of the original payment being paid by the bank.  A screen print of the replacement check (#FE20174892) is attached for your review.  It was mailed on 10-13-22 to North East Baptist Hospital, P.O. Box 84833, Dallas, Texas 75284.  There is no records of this check being paid by the bank either."

**Response Submitted by:** ESIS

## 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 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out reimbursement guidelines for workers' compensation services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 29 – The time limit for filing has expired
- 18 – Duplicate claim/service

Issues

1. Did the insurance carrier maintain the denial of timely filing?
2. Did the insurance carrier support payment of the disputed services?
3. What rule is applicable to the disputed services?

Findings

1. The insurance carrier did not maintain the denial for timely filing and states adjudication of the disputed outpatient hospital services rendered in September 2021 has processed.
2. The insurance carrier has responded that the disputed charges were paid but also states neither the initial payment nor the replacement check has been processed by the bank.  The services in dispute will be reviewed per the applicable fee guidelines.

3. 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 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 A9150 has status indicator B, for codes not paid under OPPS—these codes may not be reported on an outpatient hospital bill (type 12x and 13x). Payment is not recommended.
   - Procedure code A9150 has status indicator B, for codes not paid under OPPS—these codes may not be reported on an outpatient hospital bill (type 12x and 13x). Payment is not recommended.
   - Procedure code C1781 has status indicator N, for packaged codes integral to the total service package with no separate payment.
   - Procedure code 80048, billed September 23, 2021, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 85025, billed September 23, 2021, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Per Medicare policy, procedure code U0003, billed September 23, 2021, is included with payment for the primary services.
   - Per Medicare policy, procedure code U0005, billed September 23, 2021, is included with payment for the primary services.

- Procedure code 49585 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 5341. The OPPS Addendum A rate is $3,183.41 multiplied by 60% for an unadjusted labor amount of $1,910.05, in turn multiplied by facility wage index 0.8474 for an adjusted labor amount of $1,618.58.

  The non-labor portion is 40% of the APC rate, or $1,273.36.

  The sum of the labor and non-labor portions is $2,891.94.

  The Medicare facility specific amount is $2,891.94 multiplied by 200% for a MAR of $5,783.88.

- Procedure code 1999 has status indicator N reimbursement is included with payment for the primary services.

3. The total recommended reimbursement for the disputed services is $5,783.88. The insurance carrier paid $0.00. The amount due is $5,783.88. 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 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 Starr Indemnity & Liability Co must remit to Northeast Baptist Hospital $5,783.88 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | May 23, 2023 |
|---|---|---|
| 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.