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**
St Joseph Medical Center

**Respondent Name**
American Zurich Insurance Co

**MFDR Tracking Number**
M4-23-0686-01

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

**DWC Date Received**
November 16, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| November 23, 2021 | Emergency Services | $459.55 | $0.00 |
| | Total | $459.55 | $0.00 |

## Requestor's Position

"This bill and appeal have both been denied as not related to the work injury. There is adiscrepency between the right and left leg being covered by the claim. Both the initial and corrected bills were denied."

**Amount in Dispute:** $459.55

## Respondent's Position

"...based upon the medical records attached with the medical bill, it appears that the provider's seeking a condition that is part of the compensable injury. Accordingly, the carrier is reprocessing the provider's bill. When the provider receives payment, if the provder is in agreement with the carrier's action, we would ask that the provider withdraw its request for medical fee dispute resolution."

**Response submitted by:** Flahive, Ogden and 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:

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – In accordance with the TDI-DWC Rule 134.804,. this bill has been identified as a request for reconsideration or appeal

Issues

1. Did the respondent support payment made per fee guideline?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of emergency room services rendered in November 2021. The respondent submitted a copy of a re-evaluation that indicates a post date of November 30, 2022 with a paid amount of $463.51 under check # 1877024176.
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 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 12001 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 paid separately only if OPPS criteria are met.

- Procedure code 99283 has status indicator J2, for outpatient visits subject to comprehensive packaging if 8 or more hours observation billed. Review of the submitted medical bill found no observation hours billed, the criteria for comprehensive packaging is not met.

  This code is assigned APC 5023. The OPPS Addendum A rate is $231.60 multiplied by 60% for an unadjusted labor amount of $138.96, in turn multiplied by facility wage index 1.0011 for an adjusted labor amount of $139.11.

  The non-labor portion is 40% of the APC rate, or $92.64.

  The sum of the labor and non-labor portions is $231.75.

  The Medicare facility specific amount is $231.75 multiplied by 200% for a MAR of $463.50.

- Procedure code J2001 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

The total recommended reimbursement for the disputed services is $463.50. The insurance carrier paid $463.51. No additional payment 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 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 | April 28, 2023<br>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.