Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Providence Memorial Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-23-1547-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 9, 2022	70450	$25.23	$0.00
August 9, 2022	99284/25	$702.24	$0.00
	Total	$727.47	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. The requestor did submit copy of their reconsideration that states, "After reviewing the payment, we realized that there is an underpayment on the claim. According to our Workers Compensation contract, we are entitled to receive $894.17. We received a payment of $411.93 and we are requesting an additional amount of $482.24."

Amount in Dispute: $727.47

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 – guidelines for Medical Services, Charges and Payments."

Response submitted by: Texas Mutual

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:

- A16 – The reimbursement for health care services are subject to Workwell, TX contracts, a certified WC HCN
- CAC - P12 – Workers' compensation jurisdictional fee schedule adjustment
- CAC 131 – Claim specific negotiated discount
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 767 – Paid per O/P FG at 200%: Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403 (G)
- 920 – Reimbursement is being allowed based upon a dispute

Issues

1. Did the respondent support payment of disputed services?
2. What rule is applicable to disputed service?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of outpatient emergency room services rendered in August of 2022. The respondent submitted an explanation of benefits dated April 12, 2023 that indicates payment in the amount of $688.21 for Code 99284 and $21.40 interest. The respondent indicates that check #0350352 for $709.61 has cleared their bank.

The requestor states in their reconsideration a prior payment of $411.93 was made. Neither party included an explanation of benefits indicating this payment.

Based on the statement of the respondent and requestor, a total of $1,100.14 was made for the disputed services. The requestor did not withdraw this dispute. These services will be reviewed per the applicable fee guideline.

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 70450 has status indicator Q3. This code can be part of a composite APC when more than one of the same family of procedures is rendered on the same day.

  This code is assigned APC 5522. The OPPS Addendum A rate is $111.19 multiplied by 60% for an unadjusted labor amount of $66.71, in turn multiplied by facility wage index 0.8249 for an adjusted labor amount of $55.03.

  The non-labor portion is 40% of the APC rate, or $44.48.

  The sum of the labor and non-labor portions is $99.51.

  The Medicare facility specific amount is $99.51multiplied by 200% for a MAR of $199.02.

- Procedure code 76815 has status indicator Q1, for STV-packaged codes; reimbursement is included with payment for any other service assigned status S, T or V—not separately paid unless no such services are billed. This code is assigned APC 5522. The OPPS Addendum A rate is $111.19 multiplied by 60% for an unadjusted labor amount of $66.71, in turn multiplied by facility wage index 0.8249 for an adjusted labor amount of $55.03.

  The non-labor portion is 40% of the APC rate, or $44.48.

  The sum of the labor and non-labor portions is $99.51.

  The Medicare facility specific amount is $99.51multiplied by 200% for a MAR of $199.02.

- Procedure code 99284 has status indicator J2 when billed with 8 or more hours observation billed. This code is assigned APC 5024 with a status indicator of V.

  The OPPS Addendum A rate is $371.52 multiplied by 60% for an unadjusted labor amount of $222.91, in turn multiplied by facility wage index 0.8249 for an adjusted labor amount of $183.88.

  The non-labor portion is 40% of the APC rate, or $148.61.

  The sum of the labor and non-labor portions is $332.49.

  The Medicare facility specific amount is $332.49 multiplied by 200% for a MAR of $664.98.

3. The total recommended reimbursement for the disputed services is $1,063.02. The insurance carrier paid $1,100.14. Additional payment is not recommended.

<u>Conclusion</u>

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

June 8, 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.