TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Texas Health Fort Worth

Respondent Name
Tarrant County Hospital District

MFDR Tracking Number
M4-23-2934-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 19, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 16, 2023	250	$0.00	$0.00
February 17, 2023	250	$0.00	$0.00
February 16, 2023	272	$0.00	$0.00
February 17, 2023	272	$0.00	$0.00
February 17, 2023	300	$0.00	$0.00
February 17, 2023	301	$0.00	$0.00
February 16, 2023	450	$0.00	$0.00
February 16, 2023	450	$0.00	$0.00
February 16, 2023	450	$0.00	$0.00
February 16, 2023	450	$0.00	$0.00
February 17, 2023	450	$0.00	$0.00
February 16, 2023	450	$2,861.95	$2,861.95
February 16, 2023	612	$0.00	$0.00
February 16, 2023	636	$0.00	$0.00
February 16, 2023	636	$0.00	$0.00
February 16, 2023	636	$0.00	$0.00
February 16, 2023	636	$0.00	$0.00
February 16, 2023	636	$0.00	$0.00
February 16, 2023	636	$0.00	$0.00
February 17, 2023	636	$0.00	$0.00

February 16, 2023	762	$0.00	$0.00
February 17, 2023	762	$0.00	$0.00
	Total	$2,861.95	$2,861.95

Requestor's Position

"Our calculations are based on the Medicare outpatient rates for CPT code 99285[sic], which is $4,739.89, and the outpatient work comp multiplier is 200% without separate implant reimbursement per rule 134.403. …the total work comp fee schedule allowance is $4,739.89, and finally, deducting the payment $1,877.94, **leaves an unpaid balance due of $2,861.95**."

Amount in Dispute: $2,861.95

Respondent's Position

"The provider claims that is entitled to additional payment based on CPT code 99215[sic]… However, the provider's UB-04s never billed under CPT code 99285. The provider is not permitted to include a CPT code in its DWC 60 that not previously submitted on its bill to the carrier. …The provider is not entitled to any additional payments."

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:

- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 56 – Significant, separately identifiable e/m service rendered.

- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 926 – The recommended allowance is based on Medicare clinical lab schedule.
- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
- 97 – Payment adjusted because 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.

Issues

1. What rule is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of emergency room services rendered on February 16 – 17, 2023. The insurance carrier reduced the allowed amounts based on packaging and workers' compensation fee schedule.

   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 99284 has status indicator J2, for outpatient visits subject to comprehensive packaging when 8 or more hours observation billed.

  This code is assigned APC 8011. The OPPS Addendum A rate is $2,439.02 multiplied by 60% for an unadjusted labor amount of $1,463.41, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $1,394.34.

  The non-labor portion is 40% of the APC rate, or $975.61.

  The sum of the labor and non-labor portions is $2,369.95.

  The Medicare facility specific amount is $2,439.02 multiplied by 200% for a MAR of $4,878.04.

2. The total recommended reimbursement for the disputed services is $4,878.04. The insurance carrier paid $1,877.94. The requestor is seeking additional reimbursement of $2,861.95. 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 of $2,861.95 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 Tarrant County Hospital District must remit to Texas Health Fort Worth $2,861.95 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 17, 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.