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
VHS Brownsville Hospital

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-23-3134-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 1, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 5, 2022	99283	$431.34	$0.00
	Total	$431.34	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR) they did submit a copy of their reconsideration that states, "Occasionally circumstances beyond the control of our organization occur and in this case, initial bill was sent to WORKERS COMP on 12/20/22 via USPS certified tracking number 9414809206356205599515, which was available for pick up on 1/1/23 and bill package was never picked up at USPS facility. Bill was then sent again to WORKERS COMP on 5/4/23."

Amount in Dispute: $431.34

Respondent's Position

"The carrier has reconsidered its position. It is in agreement with the provider. The carrier has reprocessed the provider's bill and is issuing payment to the provider in the amount of $431.34 plus interest in the amount of $18.07."

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 the payment for the disputed services with the following claim adjustment codes:

- 29 – The time limit for filing claim/bill has expired
- 4271 – Per TX Labor Code Sec 408.027, providers must submit bills to payors within 95 days of the date of service.
- 2008 – Additional payment made on appeal/reconsideration.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 947 – Upheld, no additional allowance has been recommended.
- 948 – Re-reviewed at providers request with additional information and documentation additional payment suggested.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal.

Issues

1. What rule is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of outpatient hospital emergency room services. The insurance carrier provided evidence of payment in the amount of $431.34 on August 24, 2023 via electronic funds transfer EFT Tracer Number 488312. The applicable fee guideline is shown below.

   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 99283 has status indicator V, for an outpatient visit paid by APC. This code is assigned APC 5023. The OPPS Addendum A rate is $236.35 multiplied by 60% for an unadjusted labor amount of $141.81, in turn multiplied by facility wage index 0.8542 for an adjusted labor amount of $121.13.

     The non-labor portion is 40% of the APC rate, or $94.54.

     The sum of the labor and non-labor portions is $215.67.

     The Medicare facility specific amount is $215.67 multiplied by 200% for a MAR of $431.34.

2. The total recommended reimbursement for the disputed services is $431.34. The insurance carrier paid $431.34. 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 30, 2023 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.