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
Midland Memorial Hospital

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-23-3293-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 5, 2023	Outpatient Procedure	$3,337.89	$3,337.89
	Total	$3,337.89	$3,337.89

Requestor's Position

"This bill remains underpaid after appeal."

Amount in Dispute: $3,337.89

Respondent's Position

"The EOBs explain the carrier's position with respect to the reimbursement amount. It is the carrier's position that the provider is not entitled to any additional payment. The provider has been paid in accordance with the Medical Fee Guidelines."

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:

- 18 – Exact duplicate claim/service.
- 252 – An attachment /other documentation is required to adjudicate this claim/service
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- TX253 – In order to review this charge please submit a copy of the certified invoice.
- TX 370 – This Hospital Outpatient Allowance was calculated according to the APC rate, plus a markup.
- TX618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- TX619 – The procedure/supply was not sufficiently identified and/or quantified.

Issues

1. Did the requestor request separate reimbursement for implants?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services. The insurance carrier paid the Medicare facility specific amount x 130% rather than 200%. Review of the submitted medical bill found a request for separate reimbursement of the implants was not requested. The Medicare facility specific amount will be reviewed per applicable fee guideline when the requestor does not request separate reimbursement of implants.

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. DWC Rule §134.403 (e) (2) states in pertinent part, regardless of billed amount reimbursement shall be if not contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) under subsection (f). DWC Rule §134.403 (f)(1)(A) states in pertinent part, the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent.

   Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - Procedure code 21462 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 5165. The OPPS Addendum A rate is $5,339.67 multiplied by 60% for an unadjusted labor amount of $3,203.80, in turn multiplied by facility wage index 0.8372 for an adjusted labor amount of $2,682.22.

     The non-labor portion is 40% of the APC rate, or $2,135.87.

     The sum of the labor and non-labor portions is $4,818.09.

     The Medicare facility specific amount is $4,818.09 multiplied by 200% for a MAR of $9,636.18.

3. The total recommended reimbursement for the disputed services is $9,636.18. The insurance carrier paid $6,240.61. The requestor is seeking additional reimbursement of $3,337.89. 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 Insurance Co of the State of PA must remit to Midland Memorial Hospital $3,337.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 22, 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.