



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Midland Memorial Hospital

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-23-3302-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

August 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 13 – 15, 2023	Emergency Visit	\$3,759.19	\$3,759.19
	Total	\$3,759.19	\$3,759.19

Requestor's Position

"This bill remains underpaid after appeal."

Amount in Dispute: \$3,759.19

Respondent's Position

"Midland County Hospital District did not submit an appeal to Texas Mutual upon receiving the first denial, therefore did not fully comply per Rule 133.307(J)... ..Our position is that no payment is due."

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:

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-18 – Exact duplicate claim/service.
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 767 – Paid per O/P FG at 200: Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(G).
- 224 – Duplicate charge.
- 892 – Denied in accordance with DWC Rules and/or Medical fee guideline including current CPT Code descriptions/instructions.

Issues

1. Is the respondent's position supported?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The respondent states in their position, "Midland County Hospital District did not submit an appeal to Texas Mutual..." Review of the submitted documents included with this request found, a request for reconsideration dated July 18, 2023 was sent to Texas Mutual for the disputed date of service. Texas Mutual processed a claim for the disputed date of service on August 11, 2023 and denied as a duplicate charge. The submitted documentation supports a request for reconsideration was made but Texas Mutual processed as a duplicate. The respondent's position is not supported. The services in dispute will be reviewed per applicable fee guidelines.
2. The requestor is seeking additional payment of outpatient emergency room services rendered in April of 2023. 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 99285, billed April 13, 2023, has status indicator J2, for outpatient visits subject to comprehensive packaging since more than 8 hours observation was 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 0.8372 for an adjusted labor amount of \$1,225.17.

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

The sum of the labor and non-labor portions is \$2,200.78.

The Medicare facility specific amount is \$2,200.78 multiplied by 200% for a MAR of \$4,401.56.

- Procedure code J0841, billed April 13, 2023, has status indicator K, for nonpass-through drugs and biologicals separately paid by APC.

This code is assigned APC 9188. The OPPS Addendum A rate is \$433.91 multiplied by 60% for an unadjusted labor amount of \$260.35, in turn multiplied by facility wage index 0.8372 for an adjusted labor amount of \$217.97.

The non-labor portion is 40% of the APC rate, or \$173.56.

The sum of the labor and non-labor portions is \$391.53 multiplied by 10 units is \$3,910.53.

The Medicare facility specific amount is \$3,915.30. This is multiplied by 200% for a MAR of \$7,830.60.

2. The total recommended reimbursement for the disputed services is \$12,232.16. The insurance carrier paid \$4,401.55. The requestor is seeking additional reimbursement of \$3,759.19. 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 \$3,759.19 additional reimbursement for the disputed services. It is ordered that Texas Mutual Insurance Co must remit to Midland Memorial Hospital \$3,759.19 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

October 6, 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 electrónico CompConnection@tdi.texas.gov.