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
Texas Regional Medical Center

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-24-0230-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 13, 2023	96365	$401.44	$401.44
January 13, 2023	99284/25	$741.61	$741.60
	Total	$1,143.05	$1,143.04

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled, "Reconsideration" addressed to the Texas Department of Insurance (TDI). Requests for reconsideration must be submitted to the correct workers' compensation carrier not TDI. This document states, "Per EOB received payment was disallowed for CPT code 99284 and 96365 due to submitted documentation does not support services being billed. Please note that medical records are enclosed for review."

Amount in Dispute: $1,143.05

Respondent's Position

"This request will be standing on the previous allowance of $1143.05, and no additional allowance is recommended as the charges were paid correctly per the TX Fee Schedule on check

#10302074 paid on 10/19/2023."

Response submitted by: TASB Risk Fund

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.
3. 28 TAC §134.600 sets out the prior authorization requirements for emergency room services.
4. 28 TAC §133.2 defines an emergency.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 16 – Claim/service lacks information or has submission/billing error(s).
- 205 – This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 95 – Plan procedures not followed.
- 97 – 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.
- U00 – There was no UR procedure/treatment request received.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the respondent support their position statement?
2. Are the respondent's denials supported?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "… charges were paid correctly per TX Fee Schedule on check #10302074 paid on 10/19/2023. Review of the submitted documentation found no document with this date or check number.

   The Division found insufficient evidence that the disputed outpatient hospital services were paid per applicable fee guideline. The respondent's position is not supported. The disputed services will be reviewed per applicable fee guideline.

2. The requestor is seeking payment of outpatient hospital emergency room services rendered in January, 2023. The insurance carrier denied the charges as packaged, no utilization review (UR) requested, claim errors/lack of documentation, and plan procedures not followed.

   DWC Rule 28 TAC §134.600 (p) (2) states in pertinent parts, "Non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services."

   DWC Rule 28 TAC §134.600 (c) (1) (A) states in pertinent part, "The insurance carrier is liable for all reasonable and necessary medial costs relating to the health care listed in subsection (p) or (q) only when following situations occur: an emergency as defined in Chapter 133 of this title…"

   DWC Rule 28 TAC 133.2 (5) (A) (i)(ii) states,

   (5) Emergency--Either a medical or mental health emergency as follows:

   (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

   (i) placing the patient's health or bodily functions in serious jeopardy, or

   (ii) serious dysfunction of any body organ or part;

Review of the submitted medical records found the injured worker had a work related injury resulting in a fracture that required immediate medical attention. The insurance carrier's denial for lack of utilization review or prior authorization is not supported, the insurance carrier is liable for the emergency care rendered on January 13, 2023. The denials related to packaging and lack of information/billing errors are not supported.

3. 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 96365 has status indicator S, for procedures not subject to reduction.

  This code is assigned APC 5693. The OPPS Addendum A rate is $206.57 multiplied by 60% for an unadjusted labor amount of $123.94, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $118.09.

  The non-labor portion is 40% of the APC rate, or $82.63.

  The sum of the labor and non-labor portions is $200.72.

  The Medicare facility specific amount is $200.72 multiplied by 200% for a MAR of $401.44.

- Procedure code 99284-25 has status indicator V, for an outpatient visit paid by APC.

  This code is assigned APC 5024. The OPPS Addendum A rate is $381.61 multiplied by 60% for an unadjusted labor amount of $228.97, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $218.16.

The non-labor portion is 40% of the APC rate, or $152.64.

The sum of the labor and non-labor portions is $370.80.

The Medicare facility specific amount is $370.80 multiplied by 200% for a MAR of $741.60.

4. The total recommended reimbursement for the disputed services is $1,143.04. The insurance carrier paid $0.00. The amount due is $1,143.04. 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled reimbursement for the disputed services. It is ordered that TASB must remit to Texas Regional Medical Center $1,143.04 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 2, 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.