



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Health Southwest

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-24-0251-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 3, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 20, 2023	36415	Left Blank	Left Blank
March 20, 2023	80053	Left Blank	Left Blank
March 20, 2023	85025	Left Blank	Left Blank
March 20, 2023	85610	Left Blank	Left Blank
March 20, 2023	85730	Left Blank	Left Blank
March 20, 2023	96374	Left Blank	Left Blank
March 20, 2023	99284	Left Blank	Left Blank
March 20, 2023	C9113	Left Blank	Left Blank
March 20, 2023	93005	Left Blank	Left Blank
	Total	\$1145.44	\$1144.74

Requestor's Position

"The claim referenced below was billed with CPT Code 96374 AND 99284, and the Medicare reimbursement is \$1,145.44 as referenced in the copy of the Medicare Pricer included in this request."

Amount in Dispute: \$1145.44

Respondent's Position

"The carrier's position is that the provider is not entitled to payment."

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.
3. [28 TAC §133.2](#) defines emergency.

Denial Reasons

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

- 11 – The diagnosis is inconsistent with the procedure.
- 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.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- W3 – Additional payment made on appeal/reconsideration.

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to reimbursement?

Findings

1. The requestor is seeking payment of outpatient emergency room services rendered on March 20, 2023. The insurance carrier denied the disputed charges stating the diagnosis is inconsistent with the procedure.

DWC Rule 28 TAC §133.2 (5)(A)(i)(ii) states 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 placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part.

Review of the submitted medical bill and supporting documentation indicates the claimant was seen and treated for symptoms that meet the definition of emergency. The insurance carrier's denial for the diagnosis being inconsistent to the emergency room visit is not supported. The services in dispute will be reviewed per applicable fee guideline.

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

- Procedure code 96374 has status indicator S.

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 0.9552 for an adjusted labor amount of \$118.39.

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

The sum of the labor and non-labor portions is \$201.02.

The Medicare facility specific amount is \$201.02 multiplied by 200% for a MAR of \$402.04.

- Procedure code 99284 has status indicator V.

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 0.9552 for an adjusted labor amount of \$218.71.

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

The sum of the labor and non-labor portions is \$371.35.

The Medicare facility specific amount is \$371.35 multiplied by 200% for a MAR of \$742.70.

3. The total recommended reimbursement for the disputed services is \$1,144.74. The insurance carrier paid \$0.00. The amount due is \$1,144.74. 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 American Zurich Insurance Co must remit to Texas Health Southwest \$1,144.74 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

November 2, 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.