TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Texas Health Fort Worth

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-24-0903-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 6, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 5, 2023	0250	Left blank	$0.00
July 5, 2023	0450	Left blank	$356.42
July 5, 2023	0450	Left blank	$476.18
	Total	$1,630.63	$832.60

Requestor's Position

"Please review the attached information and reprocess our claim for the payment due us for the services provided to the claimant."

Amount in Dispute: $1,630.63

Respondent's Position

"Since the provider is not submitted a request for reconsideration that covers the July 7, 2023 date of service, the provider is not entitled to Medical Fee Dispute Resolution."

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the requirements for prior authorization.
3. 28 TAC §133.2 defines emergency.
4. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

- 5264 – Payment is denied-service not authorized.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the respondent's position supported?
2. Is the insurance carrier's denial supported?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "Since the provider is not submitted a request for reconsideration that covers the July 7, 2023 date of service, the provider is not entitled to Medical Fee Dispute Resolution."

   A review of the submitted documentation finds a request for reconsideration dated September 20, 2023 was submitted for the disputed service.

   The insurance carrier processed this request on September 29 2023, and upheld their original denial. Based on these documents, the insurance carrier's position is not supported and will not be considered in this review.

2. The requestor is seeking payment of emergency room services rendered in an outpatient hospital setting. The insurance carrier denied the claim based on lack of prior authorization. DWC Rule 28 TAC §134.600 (p)(2) states in pertinent part, "Non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services…"

   DWC Rule §133.2 (5) defines emergency as, 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;

   A review of the submitted medical bill found emergency services were rendered to the claimant that meets the definition of an emergency.

   DWC Rule 28 TAC §134.600 (c)(1)(A) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to health care (1) listed in subsection (p)(q) of this section only when the following situations occur (A) an emergency,"

   Based on the above, the insurance carrier's denial is not supported. The insurance carrier is liable for the emergency services.

   The disputed service will be reviewed per applicable fee guideline.

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

- Procedure code 10060 has status indicator T and is assigned APC 5051. The OPPS Addendum A rate is $180.58 is multiplied by 60% for an unadjusted labor amount of $108.35, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $103.24.

  The non-labor portion is 40% of the APC rate, or $72.23.

  The sum of the labor and non-labor portions is $175.47.

  The Medicare facility specific amount is $178.21 multiplied by 200% for a MAR of $356.42.

- Procedure code 99283 has status indicator V as the criteria of comprehensive packaging if 8 or more hours observation was not billed to qualify for J2.

  This code is assigned APC 5023. The OPPS Addendum A rate is $245.03 multiplied by 60% for an unadjusted labor amount of $147.02, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $140.08.

  The non-labor portion is 40% of the APC rate, or $98.01.

  The sum of the labor and non-labor portions is $238.09.

  The Medicare facility specific amount is $238.09 multiplied by 200% for a MAR of $476.18.

4. The total recommended reimbursement for the disputed services is $832.60. The insurance carrier paid $0.00. The amount due is $832.60. 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 AIU Insurance Co must remit to Texas Health Fort Worth $832.60 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 26, 2024
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.