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
VHS Harlingen Hospital

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-24-2012-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 1, 2023	71045	$159.48	All inclusive
November 1, 2023	70450	$196.20	All inclusive
November 1, 2023	96374-XU	$379.20	All inclusive
November 1, 2023	96375-XU	$77.78	All inclusive
November 1, 2023	99285-25	$1,006.18	$3,013.16
	Total	$3,013.16	$3,013.16

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a reconsideration dated January 8, 2024 that states, "The services provided to your member were medically necessary, consistent with national standard of care, covered by the plan and bill appropriately. Furthermore, per conversation on 11/3/23, with Nancy, stated that patient is covered under TASB worker's compensation. Rep also stated that no authorization was required since patient was admitted through the Emergency Room."

Amount in Dispute: $3,013.16

Respondent's Position

The Austin carrier representative for TASB Risk Management Fund is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on May 21, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available."

Response submitted by: N/A

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 §124.2 sets out requirements of plain language notification.
3. 28 TAC §134.600 sets our requirements of prior authorization.
4. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 197 – Precertification/authorization/notification absent.
- 219, 751 – Based on extent of injury.
- 240 – Preauthorization not obtained.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate.
- P12 – Workers compensation jurisdictional fee schedule adjustment.
- 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.

Issues

1. What is the rule applicable to adjudication?
2. Was prior authorization required?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment for emergency room services rendered from November 1, 2023, through November 3, 2023. The insurance carrier denied the disputed services based on extent of injury.

   DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."
   Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported.

   Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution.

   Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

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

   The requestor submitted the "Emergency/Urgent Care" record. On page 18 of this record it is noted, "…presents to the ED via EMS for evaluation of a (redacted) onset today." Continued review of the medical record indicates the injured worker remained for outpatient observation for forty-eight hours in the emergency room.

   The DWC finds the insurance carrier is liable for the outpatient emergency room/observation services.

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)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits that complies with Labor Code §413.011, 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 sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found a request for implants was made. The Medicare facility specific reimbursement amount will be multiplied by 130 percent.

   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 71045 has a status indicator of Q3 and is packaged into primary procedure.
   - Procedure code 70450 has a status indicator of Q3 and is packaged into primary procedure.
   - Procedure code 96374-XU has a status indicator of S and is packaged into primary procedure.
   - Procedure code 96375-XU has a status indicator of S and is packaged into primary procedure.
   - Procedure code 99285-25 has status indicator J2. This code is assigned APC 8011 when eight or more hours of observation is billed. Review of the submitted medical bill found 48

hours of observation were billed. The criteria for comprehensive observation criteria are met.

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 0.9436 for an adjusted labor amount of $1,380.87.

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

The sum of the labor and non-labor portions is $2,356.48.

The Medicare facility specific amount is $2,356.48 multiplied by 200% for a MAR of $4,712.96.

4. The total recommended reimbursement for the disputed services is $4,712.96. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $3,013.16. 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 TASB Risk Management Fund must remit to VHS Harlingen Hospital $3,013.16 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	August 7, 2024 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.