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
Methodist Health System

Respondent Name
Hartford Accident & Indemnity Co

MFDR Tracking Number
M4-24-2243-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
June 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 12 – 14, 2023	Emergency Visit	$1,945.41	$0.00
	Total	$1,945.41	$0.00

Requestor's Position

"This bill remains underpaid."

Supplemental response dated July 29, 2024

We have not received any additional payment on the account yet.

Amount in Dispute: $1,945.41

Respondent's Position

"The original bill for dos 10/12-10/14/23 received on 2/21/24 processed and denied as past timely filing under control number 220644097 on 2/29/24. Bill was reprocessed and paid per fee and/or services were bundled/included under control number 902008729 in the amount of $4746.46 on 5/28/24.

Response submitted by: The Hartford

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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 29 – The time limit for filing has expired.
- 4271 – Per TX Labor Code Sec 408.027, providers must submit bills to payors within 95 days of the date of service.
- 56 – Significant, separately identifiable E/M service rendered.
- 96 – Non-covered charge(s)
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 – Bill is a reconsideration or appeal.
- 797 – Service not paid under Medicare OPPS.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 926 – The recommended allowance is based on Medicare Clinical Lab schedule.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 2008 – Additional payment made on appeal/reconsideration.
- 4097 – Paid per fee schedule: Charge adjusted because statute allowance is greater than provider's charge.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment for outpatient hospital services rendered from October 12 – 14, 2023. The services were rendered while the injured worker remained in the emergency room receiving a wide variety of medical services that included forty-one hours of observation. The insurance carrier reduced the allowed amount based on the OPPS fee schedule, and packaging. The initial denial for non-timely submission of the medical bill was not maintained.

   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. Review of the submitted medical bill found implants are not applicable. The Medicare facility specific reimbursement amount will be multiplied by 200 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 99285 has a status indicator of J2 - Comprehensive APC payment based

on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment…, The specifics of comprehensive observation are met when more than eight hours of observation are billed on the medical bill with emergency room services.

The APC associated with comprehensive observation is 8011 with a payment rate of $2,439.02 multiplied by 60% is $1,463.41 multiplied by facility wage index of 0.9331 equals the labor adjustment amount of $1365.51.

The non labor rate is ($2,439.02 x 40%) = $975.61.

The sum of the labor and non-labor rates is $2,341.12.

Total Medicare facility specific allowable $2,341.12 multiplied by 200 percent equals MAR of $4,682.24.

2. The total recommended reimbursement for the disputed services is $4,682.24. The insurance carrier paid $4,746.46. No additional payment 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 requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		August 9, 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.