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
Old Republic Insurance Co

MFDR Tracking Number
M4-24-2340-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
June 20, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 4, 2023	Emergency Visit	$898.11	$860.03
	Total	$898.11	$860.03

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $898.11

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response submitted by: Gallagher Bassett

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 the requirements of plain language notification.
3. 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.

- 5721 – To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests, submit a copy of this EOR (illegible).
- 86K10, ZK10 – A payment or denial has already been recommended for this service.
- 90202, B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- P6 – Based on entitlement to benefits.

Issues

1. Did the respondent include a copy of a PL1 notice as required by rule?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the emergency room services based on entitlement to benefits. 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).

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 entitlement to benefits, 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 requestor is seeking payment for emergency room services rendered in October of 2023. As the insurance carrier did not support the denial of entitlement to benefits, the services in dispute are reviewed per applicable fee guidelines.

   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 implants are not applicable.

   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 80053 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 85025 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 71045 has a status indicator of Q3. This code is assigned APC 5521 with an allowable of $86.88 multiplied by 60% for an unadjusted labor amount of $52.13 multiplied by facility wage index 0.9528 for an adjusted labor amount of $49.67

  The non-labor portion 40% of the APC rate, or $34.75

  The sum of the labor and nonlabor portions is $84.42 multiplied by 200% = MAR of $168.84.
- Procedure code 99284-25 has a status indicator of V as criteria for comprehensive observation is not met. This code is assigned APC 5024 with an allowable of $381.61 multiplied by 60% for an unadjusted labor amount of $228.96 in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $218.15.

  The non-labor portion 40% of the APC rate, or $127.44.

  The sum of the labor and nonlabor portions is $345.59 multiplied by 200% = MAR of $691.19
- Procedure code 93005 has a status indicator of Q1 and is packaged into primary procedure.

3. The total recommended reimbursement for the disputed services is $860.03. 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 to reimbursement for the disputed services. It is ordered that Old Republic Insurance Co must remit to Methodist Health System $860.03 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 24, 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.