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

General Information

Requestor Name
Metroplex Adventist Hospital

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-24-2906-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 26, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 11, 2024	96361	$154.83	$154.83
June 11, 2024	96375	$88.48	$0.37
June 11, 2024	96374	$366.20	$266.16
June 11, 2024	71045	$98.27	$98.27
June 11, 2024	99285	$871.81	$871.80
	Total	$1,579.59	$1,391.43

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" dated August 14, 2024, that states, "Per EOB received billed charges were not paid correctly per TX work comp guidelines. According to TX Workers Compensation Fee Schedule, Non-Surgical codes should be reimbursed at 200% GARR."

Amount in Dispute: $1,579.59

Respondent's Position

"Per the additional documentation received we stand on previous payment of $2,636.40 as the documentation received requesting additional payment does not correspond with the B04 received. (The amount billed request does not match the amount billed on the UB04)."

Response submitted by: TASB Risk Fund

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 §134.404 sets out the reimbursement guidelines for outpatient hospital charges.

Denial Reasons

- 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.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- J49 – The allowance for this line has been submitted with other allowances on the bill and re-distributed evenly.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 375 – Please see special "Note".
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 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.
- 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.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- No additional payment as billed charges request on the MFD4 M4-24-2906-01 do not match the charges on the UB04.

Issues

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

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in June of 2024. The respondent states "No additional payment as billed charges request do not match the charge on the UB04." DWC Rule 28 TAC §134.403 (e) (2) states in pertinent part, "Regardless of billed amount, reimbursement shall be: (2) if no contracted fee schedule exists 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." The MAR is calculated below.

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)(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 not made. 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 96361 has a status indicator of S. This code is assigned APC of 5691. The OPPS Addendum A rate is $45.26 multiplied by 60% for an unadjusted labor amount of in turn multiplied by facility wage index of 0.9557 for an adjusted labor rate of $27.16.

  The non-labor portion is 40% of the APC rate, or $8.10.

  The sum of the labor and non-labor portions is $44.06. The Medicare facility specific amount is $44.06 x 3 units = $132.18 multiplied by 200% for a MAR of $264.36. The insurance carrier paid $109.52. The requestor is seeking $154.83. This amount is recommended.

- Procedure code 96375 has a status indicator of S. This code is assigned APC of 5691. The OPPS Addendum A rate is $45.26 multiplied by 60% for an unadjusted labor amount of in turn multiplied by facility wage index of 0.9557 for an adjusted labor rate of $27.16.

  The non-labor portion is 40% of the APC rate, or $8.10.

  The sum of the labor and non-labor portions is $44.06.

  The Medicare facility specific amount is $44.06 multiplied by 200% for a MAR of $88.12.

- Procedure code 96374 has a status indicator of S. This code is assigned APC of 5693. The OPPS Addendum A rate is $204.22 multiplied by 60% for an unadjusted labor amount of $122.53 in turn multiplied by facility wage index of 0.9557 for an adjusted labor rate of $117.08.

  The non-labor portion is 40% of the APC rate, or $81.69.

  The sum of the labor and non-labor portions is $198.77.

  The Medicare facility specific amount is $198.77 multiplied by 200% for a MAR of $297.54.

- Procedure code 71045 has a status indicator of Q3. This code is assigned APC of 5521. The OPPS Addendum A rate is $86.58 multiplied by 60% for an unadjusted labor amount of $51.95 in turn multiplied by facility wage index of 0.9557 for an adjusted labor rate of $49.65.

  The non-labor portion is 40% of the APC rate, or $34.63.

The sum of the labor and non-labor portions is $84.28.

The Medicare facility specific amount is $84.28 multiplied by 200% for a MAR of $168.56.

- Procedure code 99285 has a status indicator of V as the criteria for comprehensive observation (J2) is not met. This code is assigned APC 5025. The OPPS Addendum A rate is $611.99. This is multiplied by 60% for an unadjusted labor amount of $367.19, in turn multiplied by facility wage index 0.9557 for an adjusted labor amount of $350.92.

  The non-labor portion is 40% of the APC rate, or $244.80.

  The sum of the labor and non-labor portions is $595.72.

  The Medicare facility specific amount is $595.72 multiplied by 200% for a MAR of $1,191.44.

3. The total recommended reimbursement for the disputed services is $2,010.02. The insurance carrier paid $618.58. The amount due is $1,391.43. 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 Metroplex Adventist Hospital $1,391.43 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	September 26, 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.