



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Hunt Regional Medical Center

Respondent Name

Pennsylvania Manufacturers Association

MFDR Tracking Number

M4-24-2938-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 23, 2023	73630	\$0.00	\$0.00
August 23, 2023	73610	\$0.00	\$0.00
August 23, 2023	99283	\$476.18	\$0.00
August 23, 2023	Rev 637	\$0.00	\$0.00
Total		\$476.18	\$0.00

Requestor's Position

"The submission was within the timely filing deadline and PMA Companies either failed to properly forward the claim to their reconsiderations department, or PMA Companies failed to properly intake the supporting documents after the claim submission from Acretis."

Amount in Dispute: \$476.18

Respondent's Position

This dispute concerns date of service August 23, 2023, and CPT 99283. Request billed \$925.00 under this code. Carrier issued reimbursement in the amount of \$476.18. The payment was calculated in accordance with the applicable fee guideline. Carrier asserts no additional reimbursement is owed."

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

- 1001 – Based on corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 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.
- 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.
- 56 – Significant, separately identifiable E/M service rendered.
- 802 – Chare for this procedure exceeds the OPPS schedule allowance.
- 847 – In accordance with OPPS guidelines, the billed revenue codes requires HCPCS/CPT coding. No separate payment is recommended for a non-package revenue code.
- 876 - Reimbursement equals the amount billed.
- 4271 – Per Tx Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- 295 – Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing.
- 4599 – Radiology report required for procedure.

Issues

1. Did the insurance carrier maintain their denial based on medical bill not submitted within 95 days?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment for outpatient hospital services rendered August 23, 2023. The insurance carrier denied as not filed timely. Information received from the respondent indicates this denial was not maintained and a payment of \$645.02 was issued on September 12, 2024, via check 11309325C. The applicable fee guideline calculation is shown 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 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.

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 reimbursement is not applicable. The facility specific 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 99283 has a status indicator of V. The APC associated with 99283 is 5023

with a payment rate of \$245.03 multiplied by 60% is \$147.02 multiplied by facility wage index of 0.9331 equals the labor adjustment amount of \$137.18.

The non labor rate is \$98.01.

Total Medicare facility specific allowable \$235.19 multiplied by 200% equal a Medical facility specific allowable of \$476.18.

3. The total recommended reimbursement for the disputed services is \$476.18. The insurance carrier paid \$476.18. The amount due is \$0.00.

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 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

_____	_____	October 2, 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 electrónico CompConnection@tdi.texas.gov.