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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-25-0143-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 19 – 21, 2024	Emergency visit	$22,987.62	$10,293.37
	Total	$22,987.62	$10,293.37

Requestor's Position

"This bill remains underpaid after appeal."

Supplemental response submitted December 11, 2024 from requestor

"We have rec'd $5006.61 and $632.22 but remains underpaid by $22,987.62."

Amount in Dispute: $22,987.62

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 – Guidelines for Medical Services, Charges and Payments."

Supplemental response submitted December 11, 2024 from Texas Mutual

"An additional $12,000.62 was issued on 10/14/2024 on check #03953681. I've attached the EOB

as well as a screen shot showing that check has cleared the bank."

Response submitted by: Texas Mutual

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 rules and fee guidelines for outpatient hospital services.

Denial Reasons

- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup.
- 618 – The value of this procedure is included in the value of another procedure performed on this date.
- 630 – This service is package with other services performed on the same date and reimbursement is based on a single composite rate.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdiction fee schedule adjustment.
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC3 – Additional reimbursement allowed after reconsideration.
- DC4 – No additional reimbursement allowed after reconsideration.
- 350 – In accordance with TDI-DWC Rule 134,804, this bill has been identified as a request for reconsideration or appeal.
- 767 – Paid per O/P fg at 200%; Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(g).
- 920 – Reimbursement is being allowed based upon a dispute.

Issues

1. What rule(s) are applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of outpatient hospital emergency room observation services. The insurance carrier reduced/denied the charges based on packaging and workers' compensation fee schedule.

   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 is 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 96375 has status indicator J2, for outpatient visits subject to comprehensive packaging when 8 or more hours observation is billed. Review of the submitted medical bill found 38 hours of observation were submitted. Comprehensive packaging requirement is met. All lines except for the one listed below are packaged into this comprehensive payment. This code is assigned APC 8011. The OPPS Addendum A rate

is $2,607.99 multiplied by 60% for an unadjusted labor amount of $1,564.79, in turn multiplied by facility wage index 0.9331 for an adjusted labor amount of $1,460.11.

The non-labor portion is 40% of the APC rate, or $1,043.20.

The sum of the labor and non-labor portions is $2,503.31.

The Medicare facility specific amount is $2,503.31 is multiplied by 200% for a MAR of $5,006.62.

- Procedure code J0840 has status indicator K, for nonpass-through drugs and biologicals separately paid by APC. This code is assigned APC 9274. The OPPS Addendum A rate is $1,979.87 multiplied by 60% for an unadjusted labor amount of $1,187.92, in turn multiplied by facility wage index 0.9331 for an adjusted labor amount of $1,108.45.

  The non-labor portion is 40% of the APC rate, or $791.95.

  The sum of the labor and non-labor portions is $1,900.40 multiplied by 6 units is $11,402.40.

  The Medicare facility specific amount is $11,402.40 is multiplied by 200% for a MAR of $22,804.80.

3. The total recommended reimbursement for the disputed services is $27,811.42. The insurance carrier paid $17,518.05. The amount due is $10,293.37. 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 Texas Mutual must remit to Methodist Health System $10, 293.37 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	January 10, 2025 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.