



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Health Huguley

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-25-1117-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

January 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 10, 2024	96374	\$40.28	\$0.00
October 10, 2024	70450	\$97.89	\$0.00
October 10, 2024	74177	\$386.86	\$0.00
October 10, 2024	71260	\$213.25	\$0.00
October 10, 2024	72128	\$89.24	\$0.00
October 10, 2024	72125	\$95.63	\$0.00
October 10, 2024	72131	\$103.10	\$0.00
Total		\$1,026.25	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document title "Reconsideration" dated December 9, 2024 that states, "Per EOB received bill was not paid correctly per TX work comp guidelines. According to TX Workers Compensation Fee Schedule the expected reimbursement for DOS 10/10/2024 is \$3,421.62 which outpatient services should be reimbursed at 200%."

Amount in Dispute: \$1,026.25

Respondent's Position

"The bill in question was processed per the Texas Fee Guidelines. The initial bill was processed for the correct reimbursement amount. The request for reconsideration was considered and no additional reimbursement was warranted."

Response submitted by: White Espey PLLC

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

- 97 – The benefit for this service is included in the payments/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Additional payment made on appeal/reconsideration.
- 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

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 of emergency outpatient hospital charges rendered in October of 2024. The insurance carrier reduced the payment based on workers' compensation fee schedule and packaging.

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 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 are shown below.

- Procedure code 96374 has status indicator S, this code is assigned APC 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 0.9382 for an adjusted labor amount of \$114.96.

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

The sum of the labor and non-labor portions is \$196.65.

The Medicare facility specific amount is \$196.65 multiplied by 200% for a MAR of \$393.30.

- Procedure code 84703 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 73130 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into payment of code 99285.
- Procedure code 70450, 74177, 71260, 72128, 72125, 72131 have status indicator Q3, for conditionally packaged codes paid as a composite if OPPS criteria are met. These codes

meet the criteria for CT with contrast composite. This composite is assigned APC 8006. The Addendum A rate is \$427.60 multiplied by 60% for an unadjusted labor amount of \$240.70, in turn multiplied by facility wage index 0.9382 for an adjusted labor amount of \$240.70.

The non-labor portion is 40% of the APC rate, or \$244.64.

The sum of the labor and non-labor portions is \$588.91.

The Medicare facility specific amount is \$588.91 multiplied by 200% for a MAR of \$823.48.

- Procedure code 99285 has status indicator J2 if 8 or more hours observation were billed. The submitted medical claim did not meet the criteria of observation composite. This code is assigned APC 5025 with a status indicator of V. The OPPS Addendum A rate is \$611.59 this is multiplied by 60% for an unadjusted labor amount of \$366.95, in turn multiplied by facility wage index 0.9382 for an adjusted labor amount of \$344.27.

The non-labor portion is 40% of the APC rate, or \$244.64.

The sum of the labor and non-labor portions is \$588.91.

The Medicare facility specific amount is \$588.91 multiplied by 200% for a MAR of \$1,177.82.

- Procedure code Q9967 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J1885 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

3. The total recommended reimbursement for the disputed services is \$2,394.60. The insurance carrier paid \$2,395.38. Additional payment is not 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 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

March 4, 2025

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.