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
State Office of Risk Management

MFDR Tracking Number
M4-25-1835-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
April 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 21, 2024	73562	$4.17	$0.00
December 21, 2024	73110	$4.17	$0.00
December 21, 2024	73090	$4.17	$0.00
December 21, 2024	70450	$67.28	$0.00
December 21, 2024	70486	$83.83	$0.00
December 21, 2024	72125	$33.26	$0.00
December 21, 2024	99284	$20.31	$0.00
December 21, 2024	90471	$130.67	$0.00
	Total	$347.86	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated March 26, 2025 that states, "Per EOB received billed charges were not paid correctly per TX work comp guidelines. According to TX Workers Compensation Fee Schedule the expected reimbursement for DOS 12/21/2024 is $2,069.71."

Amount in Dispute: $347.86

Respondent's Position

"Effective for services furnished on or after January 1, 2009, multiple imaging procedures performed during a single session using the same imaging modality are paid by applying a composite APC payment methodology. The services are paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The I/OCE logic determines the assignment of the composite APCs for payment."

Response submitted by: SORM

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 pymt/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- W3 – Reporting purposes only.
- 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 requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment for outpatient emergency room services rendered in December of 2024. The insurance carrier reduced the payment 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 are shown below.

   - Procedure code 73562 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 Procedure code 99284 with a status indicator of V.
   - Procedure code 73110 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 Procedure code 99284 with a status indicator of V.
   - Procedure code 73090 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 Procedure code 99284 with a status indicator of V.

- Procedure code 70450, 70486 and 72125 has status indicator Q3, packaged codes paid as a composite. The OPPS Addendum A rate is $225.11 multiplied by 60% for an unadjusted labor amount of $135.07 multiplied by facility wage index 0.9557 for an adjusted labor amount of $129.09.

  The non-labor portion is 40% of the APC rate, or $90.04

  The sum of the labor and non-labor portions is $219.13.

  The Medicare facility specific amount is $219.13 multiplied by 200% for a MAR of $438.26.

- Procedure code 99284 has status indicator J2, comprehensive packaging if 8 or more hours observation billed. However, observation hours were not rendered on this date of service. This code is assigned APC 5024 with a status indicator of V. The OPPS Addendum A rate is $422.00 multiplied by 60% for an unadjusted labor amount of $253.20, in turn multiplied by facility wage index 0.9557 for an adjusted labor amount of $241.98.

  The non-labor portion is 40% of the APC rate, or $168.80.

  The sum of the labor and non-labor portions is $410.78.

  The Medicare facility specific amount is $410.78 multiplied by 200% for a MAR of $821.56.

- Procedure code 90715 has status indicator N, for packaged codes integral to the total service package with no separate payment.

- Procedure code 90471 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 procedure code 99284 with a status indicator of V.

2. The total recommended reimbursement for the disputed services is $1,259.82. The insurance carrier paid $1,721.85. 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

Signature	Medical Fee Dispute Resolution Officer	April 29, 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.