TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Flower Mound

Respondent Name
Employers Mutual Casualty Co

MFDR Tracking Number
M4-18-4731-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 3, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Texas Fee Schedule, CPT code 49585 is a bundled procedure code and has been underpaid."

Amount in Dispute: $1,996.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The request for additional reimbursement is an amount that has already been included in the carrier's initial reimbursement. The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2018	Outpatient Hospital Services	$1,996.18	$1,996.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment." 28 Texas Administrative Code §134.403 (d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided.

   The applicable Medicare payment policy is part of Medicare's Outpatient Prospective Payment System (OPPS) that assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov. The calculation of the maximum allowable reimbursement based on the Medicare payment policy and division fee guidelines is discussed below.

2. 28 Texas Administrative Code §134.403(f)(1) requires that the sum of the Medicare facility specific amount be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantable. Review of the submitted medical bill found separate reimbursement for any implantable does not apply.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 49585 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This code is assigned APC 5341. The OPPS Addendum A rate is $2,911.16, multiplied by 60% for an unadjusted labor amount of $1,746.70, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $1,704.08. The non-labor portion is 40% of the APC rate, or $1,164.46. The sum of the labor and non-labor portions is $2,868.54. The Medicare facility specific amount of $2,868.54 is multiplied by 200% for a MAR of $5,737.08.

3. The total recommended payment for the services in dispute is $5,737.08. The amount previously paid by the insurance carrier is $3,729.10, which leaves an amount due to the requestor of $1,996.18. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,996.18.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,996.18, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 28, 2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.