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 HEB

Respondent Name
Great West Casualty

MFDR Tracking Number
M4-19-3861-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
April 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $28.94

RESPONDENT'S POSITION SUMMARY

Review of the documentation finds that no response has been received on behalf of Great West Casualty Co.

The Austin carrier representative is JT Parker & Associates LLC who acknowledged receipt of the copy of this medical fee dispute on May 1st, 2019. 28 Texas Administrative Code §133.307 states, in relevant part:

> (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The division concludes that Great West Casualty failed to respond within the timeframe required by §133.307(d)(1). For that reason, the division will base its decision on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 21, 2018	Outpatient Hospital Services	$28.94	$28.94

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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed service with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carriers' reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $28.94 for outpatient hospital services rendered on December 21, 2018. The insurance carrier reduced disputed services based on the workers' compensation jurisdictional fee schedule.

   28 Texas Administrative Code §134.403 (f) states,

   > 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 following minimal modifications shall be applied.
   >
   > (1) 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 claim found no request for separate reimbursement of implants. The maximum allowable reimbursement per the above is calculated as follows:

   - Procedure code 29881 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 5113. The OPPS Addendum A rate is $2,645.23, multiplied by 60% for an unadjusted labor amount of $1,587.14, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $1,545.24. The non-labor portion is 40% of the APC rate, or $1,058.09. The sum of the labor and non-labor portions is $2,603.33. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $2,603.33 is multiplied by 200% for a MAR of $5,206.66.

2. The total recommended reimbursement for the disputed services is $5,206.66. The insurance carrier paid $5,174.92. The requestor is seeking additional reimbursement of $28.94. 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 $28.94.

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 $28.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 18, 2019
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 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.