TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor University Med Center

Respondent Name
Fedex Ground Package System

MFDR Tracking Number
M4-19-3957-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient came in Baylor facility using his group health insurance, then provided his workers' comp insurance information on 12/28/2018. The insurance carrier is refusing to pay."

Amount in Dispute: $3,693.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the carrier has reprocessed the provider's bill. We are attaching a copy of the carrier's EOR dated May 7, 2019. The recommended allowance is $1,150.22."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2018	Outpatient Hospital Services	$3,693.41	$0.00

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 services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $3,693.41 for outpatient hospital services rendered on July 31, 2018. The insurance carrier reduced disputed services based on workers compensation fee schedule.

   28 TAC §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 fill found implants are not part of the disputed services. The maximum allowable reimbursement per the above is calculated as follows:

   - 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.
   - Procedure code 99284 has status indicator J2when 8 hours or more of observation of billed otherwise, this code has a status indicator of V and is assigned APC 5024. The OPPS Addendum A rate is $355.53, multiplied by 60% for an unadjusted labor amount of $213.32, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $208.11. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is $350.32. The Medicare facility specific amount of $350.32 is multiplied by 200% for a MAR of $700.64.
   - Procedure code 96365 has status indicator S. This code is assigned APC 5693. The OPPS Addendum A rate is $191.09, multiplied by 60% for an unadjusted labor amount of $114.65, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $111.85. The non-labor portion is 40% of the APC rate, or $76.44. The sum of the labor and non-labor portions is $188.29. The Medicare facility specific amount of $188.29 is multiplied by 200% for a MAR of $376.58.
   - Procedure code 96375 has status indicator S. This code is assigned APC 5691. The OPPS Addendum A rate is $37.03, multiplied by 60% for an unadjusted labor amount of $22.22, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $21.68. The non-labor portion is 40% of the APC rate, or $14.81. The sum of the labor and non-labor portions is $36.49. The Medicare facility specific amount of $36.49 is multiplied by 200% for a MAR of $72.98.
   - Procedure code 96376 has status indicator N reimbursement is included with payment for the primary services.
   - Procedure code 90715 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J0690 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2270 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2405 has status indicator N reimbursement is included with payment for the primary services.
- 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.

2. The total recommended reimbursement for the disputed services is $1,150.20. The insurance carrier paid $1,150.22. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		May 16, 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.