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
HUNT REGIONAL MEDICAL CENTER

Respondent Name
STARR INDEMNITY & LIABILITY COMPANY

MFDR Tracking Number
M4-19-4144-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 13, 2019

Response Submitted By
Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

"Per Medicare the MRI was underpaid"

RESPONDENT'S POSITION SUMMARY

"The CPT code was 73221 PO52. … modifier 52 when used, reduces the reimbursement amount."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 20, 2018	Outpatient Facility MRI: 43221-P052	$235.72	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 hospital facility 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.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - 609 – MODIFIER 52 REDUCED SERVICES
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issue

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors modified by DWC rules.

Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for these disputed hospital facility services. Reimbursement for the disputed services is calculated as follows:

- Procedure code 73221-PO52 represents a magnetic resonance imaging (MRI) service. The OPPS Addendum A rate is $232.31, multiplied by 60% for an unadjusted labor amount of $139.39, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $135.99. The non-labor portion is 40% of the APC rate, or $92.92. The sum of the labor and non-labor portions is $228.91.

  The provider billed this code with modifier 52 (partial reduction of radiology service). Per Medicare payment policy (see *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §20.6.40), payment for this service is reduced by 50%.

  Half of the labor-adjusted rate is $114.46. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $114.46 is multiplied by 200% for a MAR of $228.91.

The total recommended reimbursement for the disputed services is $228.91. The insurance carrier paid $228.90. Additional payment is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

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

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

____________________	Grayson Richardson	June 7, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.