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 Institute for Surgery

Respondent Name
St Paul Fire & Marine Insurance Co

MFDR Tracking Number
M4-19-4221-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
May 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC for CPT 63650… *Units: 2."

Amount in Dispute: $11,892.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider was properly reimbursed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2018	63650	$11,892.04	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 802 – Charge for this procedure exceeds the OPPS schedule allowance

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional reimbursement in the amount of $11,892.04 for code 63650 rendered on November 9, 2018. The insurance carrier reduced disputed services based on workers' compensation jurisdictional fee schedule.

   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 Medicare Claims Processing Manual at www.cms.gov, Chapter 4 - Part B Hospital, Section 10.2.3 Comprehensive APCs, states in pertinent part,

> *The single payment for a comprehensive claim is based on the rate associated with either the J1 service or the specific combination of J2 services. When multiple J1 services are reported on the same claim,* ***the single payment is based on the rate associated with the highest ranking J1 service****.*

Based on the above only a single unit is allowed for claims that include J1 status indicator. The carrier's payment of only one unit is supported. No additional payment is 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

		June 27, 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.