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
Sentry Insurance A Mutual Co

MFDR Tracking Number
M4-19-4278-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 29, 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: $1,358.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We received the provider's original bill along with an itemized statement, implant invoices, and a letter on 2/1/2019. The letter stated that the provider wanted to be reimbursed separately for the implants, so we priced the implants using the submitted invoices."

Response Submitted by: Sentry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 26, 2018	29888	$1,358.66	$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

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 $1,358.66 for outpatient hospital services rendered on December 26, 2018. The insurance carrier reduced disputed services based on the 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.

The maximum allowable reimbursement per the above is calculated as follows:

- Procedure code 29888 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5114. The OPPS Addendum A rate is $5,606.42, multiplied by 60% for an unadjusted labor amount of $3,363.85, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $3,275.04. The non-labor portion is 40% of the APC rate, or $2,242.57. The sum of the labor and non-labor portions is $5,517.61. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $5,517.61 is multiplied by 130% (**the provider requested separate reimbursement for implants when the reconsideration was submitted on January 7, 2019**) for a MAR of $7,172.89.

2. The total recommended reimbursement for the disputed service is $7,172.89. The insurance carrier paid $7,181.64. 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

Signature	Medical Fee Dispute Resolution Officer	June 14, 2019 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.