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
Doctors Hospital at Renaissance

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-4279-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 29, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $9,440.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "75825 cpt code… The provider did not bill a modifier therefore the code was package into the primary procedure. 37193 cpt code has a status indicator of J1… since cpt code 37191 is the highest ranking J1 status indicator, cpt code 37193 was packaged into 37191."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2018	Outpatient Hospital Services	$9,440.16	$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
   - 97 – the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 193 – Original payment decision is being maintained.

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 $9,440.16 for outpatient hospital services rendered on January 18, 2019. The insurance carrier reduced disputed services with claim 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 bill finds implants were not separately requested. The maximum allowable reimbursement per the above is calculated as follows:

   - Procedure code 75825. This code is not separately paid as the claim contains service with J1 status indicator that is described below.
   - Procedure code 37191 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 5184. The OPPS Addendum A rate is $4,376.52, multiplied by 60% for an unadjusted labor amount of $2,625.91, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $2,159.55. The non-labor portion is 40% of the APC rate, or $1,750.61. The sum of the labor and non-labor portions is $3,910.16. The Medicare facility specific amount of $3,910.16 is multiplied by 200% for a MAR of $7,820.32.
   - Procedure code 37193 is not the highest ranking J1 code and per the Medicare Claims Processing Manual, Chapter 4, Section 10.2.3 *"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****."* No separate payment is recommended.

2. The total recommended reimbursement for the disputed services is $7,820.32. The insurance carrier paid $7,820.32. 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

		June 28, 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.