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
Seton Med Center Harker Heights

Respondent Name
Fire Insurance Exchange

MFDR Tracking Number
M4-19-4879-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
July 15, 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 Chapter 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $131.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel will maintain the requestor, Seton Medical Center Harker Heights is not entitled to additional reimbursement for date of service 07/17/18 in the amount of $131.10 based on DWC adopted medical outpatient hospital fee guidelines, Medicare payment policies and correct coding initiative (CCI) edits in effect at the time services were provided."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2018	Outpatient Hospital Services	$131.10	$131.10

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 State Fee Schedule Adj

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 $131.10 for outpatient hospital services rendered on December 6, 2018. The insurance carrier reduced disputed services based on workers compensation jurisdictional fee schedule.

   The applicable division fee guideline is 28 TAC §134.403, (f) which 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 medical bill found no separate request for implants. The maximum allowable reimbursement per the above is calculated as follows:

   - Procedure code 29881 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5113. The OPPS Addendum A rate is $2,645.23, multiplied by 60% for an unadjusted labor amount of $1,587.14, in turn multiplied by the facility wage index of 0.9701 for an adjusted labor amount of $1,539.68. The non-labor portion is 40% of the APC rate, or $1,058.09. The sum of the labor and non-labor portions is $2,597.77. The Medicare facility specific amount of $2,597.77 is multiplied by 200% for a MAR of $5,195.54.

2. The total recommended reimbursement for the disputed services is $5,195.54. The insurance carrier paid $5,061.28. The requestor is seeking additional reimbursement of $131.10. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $131.10.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $131.10, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 9, 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.