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
Doctors Hospital at Renaissance

Respondent Name
Weslaco ISD

MFDR Tracking Number
M4-19-5061-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
July 31, 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: $408.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2019	Outpatient Hospital Services	$408.07	$207.02

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 or denied the payment for the disputed services with the following claim adjustment codes:
   - 38 – Services not provided by network provider.

Issues

1. Is the denial from the insurance carrier supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

The Austin carrier representative for Weslaco ISD is Dean J Pappas law firm who acknowledged receipt of the copy of this medical fee dispute on August 8, 2019.

28 TAC §133.307 states if DWC does not receive the response information within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

No response was received, DWC will base its decision on the information available.

1. The requestor is seeking additional reimbursement in the amount of $408.07 for outpatient hospital services rendered on April 26, 2019. The insurance carrier denied the disputed services based on non-network provider.

   The carrier did not provide convincing evidence that the injured employee is enrolled in Tristar Managed Care, nor did the carrier provide documentation to support that the requestor is contracted with Tristar Managed Care. The services in dispute will be reviewed per applicable DWC fee guidelines.

2. The applicable DWC fee guideline is found in 28 TAC §134.403, (f) which states reimbursement is determined by the annual Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors and the Medicare facility specific amount being multiplied by 200 percent.

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

   - Procedure code 72100 has status indicator Q1, for STV-packaged codes. Reimbursement is packaged with payment for any service assigned status indicator S, T or V. Code G0463 has a status indicator of V so this code is packaged. No additional payment can be recommended.
   - Procedure code G0463 has status indicator J2 when billed with 8 or more hours observation. When billed with no observation this code has a status indicator of V and is assigned APC 5012.

     The OPPS Addendum A rate is $115.85, multiplied by 60% for an unadjusted labor amount of $69.51, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $57.17. The non-labor portion is 40% of the APC rate, or $46.34. The sum of the labor and non-labor portions is $103.51.

     The Medicare facility specific amount of $103.51 is multiplied by 200% for a MAR of $207.02.

3. The total recommended reimbursement for the disputed services is $207.02. The insurance carrier paid $0.00. The amount due is $207.02. 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 $207.02.

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 $207.02, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 17, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.