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
Doctor's Hospital at Renaissance

Respondent Name
Worth Casualty Co

MFDR Tracking Number
M4-19-5228-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 19, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation did not contain a position summary.

Amount in Dispute: $1,629.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After reviewing the bill, we have determined that the correct allowance has been paid per the fee guidelines and no additional allowance is being recommended."

Response Submitted by: Salus Claims Management, LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2018	73110, 73110, 73030, 73030, 70450, 71260, 74177, 99284, 29126, 96374	$1629.52	$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:
   - 802 – Charge for this procedure exceeds the OPPS schedule allowance
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 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 $1,629.52 for outpatient hospital services rendered on December 1, 2018. The insurance carrier reduced disputed services based on bundling and workers' compensation fee schedule.

   The DWC fee guideline for outpatient hospital services is 28 TAC §134.403. Section (d) of this rule instructs participants to apply Medicare payment policies.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1 which is specific to Status Indicators.

   Every HCPCS code submitted is reviewed to determine if payment is made separately or packaged.

   The applicable Medicare payment policy and DWC fee guideline for the services listed on the DWC060 is as follows:

   - Procedure code 73030 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator V or in this case Code 99284.
   - Procedure code 73030 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator V or in this case Code 99284.
   - Procedure code 73110 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator V or in this case Code 99284.
   - Procedure code 73110 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator V or in this case Code 99284.
   - Procedure code 70450 has status indicator Q3, which is a composite or combination of designated procedures. The payment is calculated below.
   - Procedure code 72125 has status indicator Q3, which is a composite or combination of designated procedures. The payment is calculated below.
   - Procedure code 71260 has status indicator Q3, which is a composite or combination of designated procedures. The payment is calculated below.
   - Procedure code 74177 has status indicator Q3, which is a composite or combination of designated procedures. The payment is calculated below.
   - Procedure code 99284 would have a status indicator J2 if the criteria for comprehensive packaging was met, but the criteria was not met. This codes' status indicator is then V and is assigned APC 5024. The OPPS Addendum A rate is $355.53, multiplied by 60% for an unadjusted labor amount of $213.32, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $176.82. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is $319.03.

     The Medicare facility specific amount is $319.03. Per 28 TAC §134.403, (f) (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent. This results in a MAR of $638.06
   - Procedure code 96374 has status indicator S and is assigned APC 5693. The OPPS Addendum A rate is $191.09, multiplied by 60% for an unadjusted labor amount of $114.65, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $95.03. The non-labor portion is 40% of the APC rate, or $76.44. The sum of the labor and non-labor portions is $171.47.

The Medicare facility specific amount of $171.47. Per 28 TAC §134.403, (f) (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent. This results in a MAR of $342.94.

- Procedure codes 70450, 74177, 72125, and 71260 have status indicator Q3, for packaged codes paid through a composite APC. This composite is assigned APC 8006. The OPPS Addendum A rate is $500.85, multiplied by 60% for an unadjusted labor amount of $300.51, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $249.09. The non-labor portion is 40% of the APC rate, or $200.34. The sum of the labor and non-labor portions is $449.43.

  The Medicare facility specific amount of $449.43. Per 28 TAC §134.403, (f) (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent. This results in a MAR of $898.86.

2. The total recommended reimbursement for the services listed on the DWC060 is $1,879.86. The insurance carrier paid $1,879.86 for these services. Additional payment is not recommended.

Conclusion

For the reasons stated above, DWC finds that the requestor has not established that additional reimbursement is due. 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

		September 24, 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 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 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.