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
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-19-5327-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 28, 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 reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. …there is a pending payment in the amount of $4,945.12."

Amount in Dispute: $4,945.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Date of service in dispute was processed in accordance with Texas Workers Compensations Guidelines, 28 TAC §134.403."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15 – 20, 2019	Outpatient Hospital Services	$4,945.12	$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
   - 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment

- 908 – In accordance with Clinical Based Coding Initiative/Outpatient Code editor procedure has been disallowed

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional reimbursement in the amount of $4,945.12 for Codes 88300, 73560, 29881, 20680 and 96374 rendered in May 2019. The insurance carrier reduced/denied the services as bundled services, workers' compensation fee schedule and NCCI edits.

   28 TAC §134.403 (d) and (f) states in pertinent parts,

   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided
   >
   > (f) 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.

   Based on the above, the codes in dispute are shown below with the Medicare payment policy found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1 and application of the applicable fee guideline.

   - Procedure code 29881 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 5113. The OPPS Addendum A rate is $2,623.34, multiplied by 60% for an unadjusted labor amount of $1,574.00, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $1,294.46. The non-labor portion is 40% of the APC rate, or $1,049.34. The sum of the labor and non-labor portions is $2,343.80. The Medicare facility specific amount of $2,343.80 is multiplied by 200% for a MAR of $4,687.60.
   - Procedure code 88300 has status indicator Q1, which is not exempt from packaging. No separate reimbursement is allowed.
   - Procedure code 73560 has status indicator Q1, which is not exempt from packaging. No separate reimbursement is allowed.
   - Procedure code 29879 has a J1 status indicator but the ranking of this code found at www.cms.gov, addenda J1 shows this code to have a ranking of 1683 which is lower than the ranking of 1793 for Code 29881. Only the highest-ranking code is eligible for reimbursement.
   - Procedure code 20680 has status indicator Q2, which is not exempt from packaging. No separate reimbursement is recommended.
   - Procedure code 96374 has a CCI edit with code 29881 and is also not exempt from packaging. No separate reimbursement is recommended.

Conclusion

For the reasons stated above, DWC 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute

Authorized Signature

		September 19, 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 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.