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
Texas Health Dallas

Respondent Name
Hartford Underwriters Insurance Co

MFDR Tracking Number
M4-20-1222-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 16, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Corrected Rebill, Underpaid/denied APC."

Amount in Dispute: $559.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 8, 2019	Outpatient Hospital Services	$559.87	$559.87

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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor)
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

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 $559.87 for Code 70549 rendered on April 8, 2019. The applicable DWC Rule is 28 §TAC 134.403 28 §TAC 134.403 (d) requires Texas workers' compensation system participants to apply Medicare payment policies in effect on the date of service when coding, billing, reporting and reimbursement

   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. Specifically, Payment Status Indicators.

   The status indicator of the disputed Code 70549 is Q3 which is defined as "Composite APC payment based on OPPS composite-specific payment criteria." The composite APC is 8008 - MRI and MRA with Contrast Composite with an allowable of $855.60. All codes on the submitted bill in the MRI category or 70553, 70546, 70549 are combined into a single payment.

   28 §TAC 134.403 (f) states the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount multiplied by 200 percent.

   The Medicare facility specific amount calculation multiplied by 200 percent is shown below.

Procedure Code	Status Indicator	APC	Payment Rate	60% labor related	2019 Wage Index Adjustment for provider 0.9736	40% non-labor related	Payment	Maximum allowable reimbursement
70549,70546, 70553	Q3	8008	$855.60	$513.36	$499.81	$342.24	$842.05	$1,684.10

2. The allowable for the disputed service is $1,684.10. The insurance carrier paid $1,122.73. The requestor is seeking $559.87. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $559.87.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $559.87, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 6, 2020 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.