



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 HEB

Respondent Name

American Casualty Co of Reading PA

MFDR Tracking Number

M4-20-1489-01

Carrier's Austin Representative

Box Number 57

MFDR Date Received

February 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.403 section E all HCPC's that are paid per the fee schedule should pay per the APC allowable at 200% regardless of the billed charges..."

Amount in Dispute: \$2,446.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier asserts that the Healthcare Provider was reimbursed correctly."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2019	Outpatient Hospital Services	\$2,446.95	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- 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
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment

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 \$2,446.95 for outpatient hospital services rendered on August 23, 2019. The insurance carrier reduced the disputed services based on workers' compensation jurisdictional fee schedule and bundling.

28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

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.

Review of the submitted medical bill found the following Medicare payment policy per status indicator:

- Procedure code 23410 has status indicator J1 for procedures paid at a comprehensive rate. The comprehensive code includes all services billed on the submitted medical bill.
 - This bill is assigned APC 5114. The OPSS Addendum A rate is \$5,699.59, multiplied by 60% for an unadjusted labor amount of \$3,419.75, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of \$3,329.47. The non-labor portion is 40% of the APC rate, or \$2,279.84. The sum of the labor and non-labor portions is \$5,609.31. The Medicare facility specific amount of \$5,609.31 is multiplied by 200% for a MAR of \$11,218.62.
2. The total recommended reimbursement for the disputed services is \$11,218.62. The insurance carrier paid \$12,043.62. Additional payment is not 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 not established payment 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, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute

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.