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
Metroplex Adventist Hospital

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-0335-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 7, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Payment received in the amount of $39.66 was underpaid."

Amount in Dispute: $616.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 5, 2018	97597	$274.59	$274.59

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 Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 Texas Administrative Code §133.403 sets out reimbursement for outpatient hospital services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - D25 – Approved non network provider for Workwell, Tx network claimant
   - 45 – Charge exceeds fee schedule maximum allowable

Issues

1. What rule is applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement as an out of network provider that sought and received authorization to perform medical services to an injured worker enrolled in a certified network. TIC 135.006 (c) states out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

   TIC 135.006 (d) (a) states billing by, and reimbursement to, contracted and out-of-network providers is subject to the requirements of the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation, as consistent with this chapter.

   The applicable DWC Rule for outpatient hospital service is found in 28 TAC 134.403 (f) and states the sum of the Medicare specific facility amount (determined by applying the most recently adopted and effective annual Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors) shall be multiplied by 200 percent unless a separate request for implants is made by the provider.

   Review of the submitted medical bill found implants were not applicable. The calculation is found below;

   - Procedure code 97597 the OPPS Addendum A rate is $168.95, multiplied by 60% for an unadjusted labor amount of $101.37, in turn multiplied by the facility wage index of 0.9701 for an adjusted labor amount of $98.34.

     The non-labor portion is 40% of the APC rate, or $67.58. The sum of the labor and non-labor portions is $165.92.

     The Medicare facility specific amount of $165.92 is multiplied by 200% for a MAR of $331.84.

2. The total recommended reimbursement for the disputed services is $331.84. The insurance carrier paid $39.66. Per requestor’s response from December 6, 2019 an additional $274.59 was requested. 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. The amount ordered is $274.59.

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 $274.59, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Peggy Miller	January , 2020
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 TAC §141.1(d).

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