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
MHHS Northeast Hospital

Respondent Name
Starbuck's Corp

MFDR Tracking Number
M4-20-0421-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
October 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As of right now, the clam is unreported and the carrier/employer has refused to set up a Workers Compensation claim or accept the medical records as a First Report of a claim per Texas Labor Code 124.1 (a) (3)."

Amount in Dispute: $3,106.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Document could not be matched to a Sedgwick Claim."

Response Submitted by: Sedgwick

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 10, 2018	Outpatient hospital services	$3,106.25	$700.56

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 §114.2 has definition of self-insured.
3. 28 Texas Administrative Code §114.10 sets out requirements of claims contractor.
4. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital claims.

Issues

1. What rule is applicable to self-insured claims?
2. How is the applicable fee guideline calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered November 10, 2018. The carrier has yet to process the claim stating they could not match to a Sedgwick claim.

   28 §114.2 (b) has the following words and terms:

   (1) Applicant--an employer that applies for an initial certificate of authority to self-insure or, once initially certified, any subsequent certificate of authority to self-insure.

   (2) Certificate--A certificate of authority to self-insure issued by the commissioner under Texas Labor Code §407.042, which entitles an employer to be a certified self-insurer and is valid only for the persons, firms, or corporations named on the certificate. For a certificate of authority to self-insure delivered, issued for delivery, or renewed on or after January 1, 1996, a sole proprietor, partner, or corporate executive officer of a business may be specifically excluded from coverage under Texas Labor Code §406.097.

   (4) Claims Contractor--A qualified claims servicing contractor.

   Review of the submitted documents found Starbuck's Corp is the applicant. A certificate of "Authority to Self-Insure" for the years 2018 and 2019 was issued by DWC. The claims contractor found for Starbucks is Sedgwick on the "TEXAS CERTIFIED SELF-INSURERS' THIRD-PARTY ADMINISTRATOR/AUSTIN REPRESENTATIVE LIST Produced by Self-Insurance Regulation as of August 30, 2019."

   Based on the above, DWC finds Sedgwick is the carrier responsible for processing the workers compensation claim.

   28 §114.10 (d) states, the claims contractor must promptly investigate each reportable injury and either pay benefits or controvert, as required by the Texas Workers' Compensation Act and division rules.

   The applicable DWC fee guideline is calculated below.

2. 28 TAC 134.403 (f) states the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount as published annually in the *Federal Register.* The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent.

   The results of this calculation are:

   - Procedure code 73120 has status indicator Q1, for STV-packaged codes and is packaged into code 99284.
   - Procedure code 99284 has status indicator V. This code 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 0.9754 for an adjusted labor amount of $208.07. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is $350.28. The Medicare facility specific amount of $350.28 is multiplied by 200% for a MAR of $700.56.

3. The total recommended reimbursement for the disputed services is $700.56. The insurance carrier paid $0.00. The amount due is $700.56. 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 $700.56.

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 $700.56, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		November 22 , 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 TAC §141.1(d).

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