TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
St Joseph Medical Center

Respondent Name
XL Specialty Insurance Co

MFDR Tracking Number
M4-20-0742-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted

Amount in Dispute: $5,171.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has previously responded to this dispute on December 13, 2019. As noted in the carrier's initial response, the carrier reprocessed the provider's bill. We are attaching a copy of the carrier's EOR date December 10, 2019. That EOR recommended reimbursement of $385.30."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 1 – 3, 2019	Outpatient Hospital Services	$5,171.92	$1,729.92

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
   - 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance

- 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 $5,171.93 for outpatient hospital services rendered from August 1 – 3, 2019. The insurance carrier reduced/denied the disputed services based on workers' compensation jurisdictional fee schedule and packaging.

   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.

   The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. Review of the disputed charges based on the Medicare payment policy and DWC fee guideline is shown below.

2. 28 TAC §134.403, (f) states 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 sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent unless separate reimbursement for implants is requested. Review of the submitted medical bill found implants are not applicable.

   The maximum allowable reimbursement per the above is calculated as follows:

   - Procedure code 99284 has status indicator J2 which is a comprehensive APC that bundles **ALL** services billed on the claim into APC 8011.

     The OPPS Addendum A rate is $2,386.80, multiplied by 60% for an unadjusted labor amount of $1,432.08, in turn multiplied by the facility wage index of 0.9754 for an adjusted labor amount of $1,396.85. The non-labor portion is 40% of the APC rate, or $954.72. The sum of the labor and non-labor portions is $2,351.57.

     The Medicare facility specific amount of $2,351.57 is multiplied by 200% for a MAR of $4,703.14.

   The total recommended reimbursement for the disputed services is $4,703.14. The insurance carrier paid $2,973.22. The amount due is $1,729.92. 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. An addition amount of $1,729.92 is ordered.

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 $1,729.92, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		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.