



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

Texas Health Dallas

Respondent Name

Monroe Guaranty Insurance Comp

MFDR Tracking Number

M4-20-0794-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

November 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: \$150.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As reflected in the attached EOB's Monroe properly reimbursed Texas Health in accordance with the Division Fee Guideline."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
\$150.60	Outpatient Hospital Services	\$150.60	\$150.60

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:
 - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
 - P12 – Workers' compensation jurisdictional fee schedule adjustment

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 \$150.60 for outpatient hospital services rendered on June 14, 2019. The insurance carrier reduced the disputed services based on workers' compensation fee schedule.

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 identifies whether the service described by the HCPCS code is paid under the OPSS and if so, whether payment is made separately or packaged. The combination of this Medicare payment policy and the DWC fee schedule is discussed below.

2. The applicable DWC Rule found at 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 (OPSS) 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 were not separately requested. The maximum allowable reimbursement per the above is calculated as follows:

- Procedure code 10120 has status indicator T and is assigned APC 5052. The OPSS Addendum A rate is \$314.08, multiplied by 60% for an unadjusted labor amount of \$188.45, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of \$183.47.
The non-labor portion is 40% of the APC rate, or \$125.63. The sum of the labor and non-labor portions is \$309.10. The Medicare facility specific amount of \$309.10 is multiplied by 200% for a MAR of \$618.20.
- Procedure code 96374 has status indicator S and is assigned APC 5693. The OPSS Addendum A rate is \$187.18, multiplied by 60% for an unadjusted labor amount of \$112.31, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of \$109.35.
The non-labor portion is 40% of the APC rate, or \$74.87. The sum of the labor and non-labor portions is \$184.22. The Medicare facility specific amount of \$184.22 is multiplied by 200% for a MAR of \$368.44.
- Procedure code 96375 has status indicator S and is assigned APC 5691. The OPSS Addendum A rate is \$37.88, multiplied by 60% for an unadjusted labor amount of \$22.73, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of \$22.13.
The non-labor portion is 40% of the APC rate, or \$15.15. The sum of the labor and non-labor portions is \$37.28 multiplied by 3 units is \$111.84. The Medicare facility specific amount of \$111.84 is multiplied by 200% for a MAR of \$223.68.
- Procedure code 99284 has status indicator V as the criteria for outpatient comprehensive packaging was not met. This code is assigned APC 5024. The OPSS Addendum A rate is \$360.37, multiplied by 60% for an unadjusted labor amount of \$216.22, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of \$210.51.
The non-labor portion is 40% of the APC rate, or \$144.15. The sum of the labor and non-labor portions is \$354.66. The Medicare facility specific amount of \$354.66 is multiplied by 200% for a MAR of \$709.32.

The total recommended reimbursement for the disputed services is \$1,919.64. The insurance carrier paid \$1,768.50. The requestor is seeking additional reimbursement of \$150.60. 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 \$150.60.

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 \$150.60, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	January 16, 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.