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
Physicians Surgical Hospital

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-0997-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted.

Amount in Dispute: $162.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual issue payment in accordance with the Outpatient OPPS/APC payment methodology."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 4, 2019	Outpatient Hospital Services	$162.86	$162.86

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
   - 767- Paid per O/O FG at 200% implants not applicable or separate reimbursement not requested per rule 134.403(g)
   - 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup

Issues

1. Is the respondent's position statement supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Texas Mutual issued payment in accordance with the Outpatient OPPS/APC payment methodology. Review of the "Wage Index" shown in the respondent's position statement was for Fiscal Year 2019.

   The date of service is in the first quart of fiscal year 2020. The Wage Index shown for this provider for this time period is 0.8444 not 0.8184 as the respondent indicates.

   The calculation based on the correct wage index 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 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 following minimal modifications shall be applied the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent; unless a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount shall be multiplied by 130 percent. Review of the submitted medical bill finds implants were not requested.

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

   - Procedure code 23430 has status indicator J1 and is assigned APC 5114. The OPPS Addendum A rate is $5,699.59. This is multiplied by 60% for an unadjusted labor amount of $3,419.75, in turn multiplied by facility wage index 0.8444 for an adjusted labor amount of $2,887.64. The non-labor portion is 40% of the APC rate, or $2,279.84. The sum of the labor and non-labor portions is $5,167.48. The Medicare facility specific amount is $5,167.48. This is multiplied by 200% for a MAR of $10,334.96.

   The total recommended reimbursement for the disputed services is $10,334.96. The insurance carrier paid $10,136.61. The requestor is seeking additional reimbursement of $162.86. 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 $162.86.

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 $162.86 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 17, 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 the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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 Texas Administrative Code §141.1(d).

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