Texas Department of Insurance
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Physicians Surgical Hospital

Respondent Name
City of Amarillo

MFDR Tracking Number
M4-20-0999-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position submitted.

Amount in Dispute: $162.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No position submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 8, 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
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

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 $162.85 for outpatient hospital services rendered on October 8, 2019. The insurance carrier reduced the disputed services based on workers compensation fee schedule.

   The applicable fee calculation rule is found in 28 TAC §134.403, (f) which states the Medicare facility specific amount shall be multiplied by 200 per cent unless separate reimbursement of implants is requested. Review of the submitted medical bill found separate implant reimbursement is not applicable.

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

   - Procedure code 29827 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure.

     This code 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. (***Please note: Medicare updates Wage Index factors every October 1st, effective for the Federal Fiscal Year – not the calendar year.)***

     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 is multiplied by 200% for a MAR of $10,334.96.

2. 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/is not 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	February 7, 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 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.