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
Doctors Hospital at Renaissance

Respondent Name
Employers Preferred Ins Co

MFDR Tracking Number
M4-20-1018-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
December 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $2,678.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bill was repriced based on Medicare Comprehensive APC Payment rules for HO providers effective 1/1/2015.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 26, 2019	29888, 29880, 96374	$2,678.26	$142.96

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
   - 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 $2,678.26 for outpatient hospital services rendered on September 26, 2019. The insurance carrier reduced the disputed services based on workers' compensation jurisdiction 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 OPPS and if so, whether payment is made separately or packaged. The disputed HCPCS code and their status indicators used to calculate the applicable DWC fee guideline is found 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.

   The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent unless separate reimbursement of implants is requested.

   Review of the submitted medical bill finds separate reimbursement of implants was not requested. The maximum allowable reimbursement per the above for the disputed services is calculated below:

   - 29888 - has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography).

     This code is assigned APC 5114. The OPPS Addendum A rate is $5,699.59, multiplied by 60% for an unadjusted labor amount of $3,419.75, in turn multiplied by the facility wage index of 0.8433 for an adjusted labor amount of $2,883.88. The non-labor portion is 40% of the APC rate, or $2,279.84. The sum of the labor and non-labor portions is $5,163.72.

     The Medicare facility specific amount of $5,163.72 is multiplied by 200% for a MAR of $10,327.44.

   - 29880 – has a status indicator of J1 however, the Medicare payment policy, Chapter 4, Section 10.2.3 found at www.cms.gov, states in pertinent part, *When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service.*

     Based on the above, the highest rank J1 code is 29888 which received reimbursement.

   - 96374 – has a status indicator of S which packed into the J1 code 29888.

The total recommended reimbursement for the disputed services is $10,327.44. The insurance carrier paid $10,184.48. The amount due is $142.96. 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 $142.96.

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 $142.96, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 15, 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.