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 Alliance

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-1039-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 23, 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: $1,278.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Additional review of the billing confirms Texas Mutual processed the bill accordingly per OPPS/APC composite payment."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 12, 2019	Outpatient Hospital Services	$1,278.80	$622.86

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:
   - P-12 Workers compensation jurisdictional fee schedule adjustment
   - 236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers Compensation State Regulations/Fee Schedule requirements
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup

- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS

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 $1,278.80 for outpatient hospital services rendered on February 12, 2019. The insurance carrier reduced/denied the disputed services based on workers' compensation fee schedule and APC codes.

   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 which 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 fee calculation based on the Medicare payment policy and DWC fee guideline is discussed below.

   28 TAC §134.403, (f) states 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 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 implants are not applicable.

   The maximum allowable reimbursement for the disputed services is as follows;

   - Procedure code 70450 has a NCCI edit with code 70496. The insurance carrier's denial is supported.
   - Procedure codes 70496, and 70498 are assigned composite APC 8006. The OPPS Addendum A rate is $480.77, multiplied by 60% for an unadjusted labor amount of $288.46, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $280.84. The non-labor portion is 40% of the APC rate, or $192.31. The sum of the labor and non-labor portions is $473.15. The Medicare facility specific amount of $473.15 is multiplied by 200% for a MAR of $946.30

   Procedure codes 70551, and 72156 have status indicator Q3 and is assigned APC 8008. The OPPS Addendum A rate is $855.60, multiplied by 60% for an unadjusted labor amount of $513.36, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $499.81. The non-labor portion is 40% of the APC rate, or $342.24. The sum of the labor and non-labor portions is $842.05. The Medicare facility specific amount of $842.05 is multiplied by 200% for a MAR of $1,684.10.

2. The total recommended reimbursement for the disputed services is $2,630.40. The insurance carrier paid $2007.54. An additional payment of $622.86 is due to the requestor.

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 $622.86.

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 $622.86, 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 22, 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.