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
PHYSICIANS SURGICAL HOSPITALS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-1173-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 10, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Healthcare provider in dispute did not provide a position statement.

Amount in Dispute: $101.01

RESPONDENT'S POSITION SUMMARY

No response received

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 16, 2019	Outpatient Hospital Services	$101.01	$101.01

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 acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers compensation jurisdictional fee schedule adjustment
   - CAC-16 – Claim/service lacks information or has submission/billing error(s). Which is needed for adjudication
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
   - 892 – Denied in accordance with DWC Rules and/or medical fee guidelines including current CPT code description/instructions

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Texas Mutual Insurance Co is Texas Mutual Insurance Co. Texas Mutual Insurance Co acknowledged receipt of the copy of this medical fee dispute on January 21, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any outlier payments be multiplied by 200 percent for the Outpatient services in dispute.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   Procedure code 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

   Procedure code 80048 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

   Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

   Procedure code 93005 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met. This code is assigned APC 5733. The OPPS Addendum A rate is $55.90. This is multiplied by 60% for an unadjusted labor amount of $33.54, in turn multiplied by facility wage index 0.8444 for an adjusted labor amount of $28.32. (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 $22.36. The sum of the labor and non-labor portions is $50.68. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $50.68. This is multiplied by 200% for a MAR of $101.36.

3. The total recommended reimbursement for the disputed services is $101.36. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $101.01. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $101.01.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $101.01, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Sandra Hernandez Medical Fee Dispute Resolution Officer	March 12, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.