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
UT Health Pittsburgh

Respondent Name
Texas Assoc of Counties Rmp

MFDR Tracking Number
M4-20-1176-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per out Texas Fee Schedule calculations, this bill has been underpaid."

Amount in Dispute: $281.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2019	Outpatient Hospital Services	$281.28	$0.00

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
    - 193 – Original payment decision is being maintained

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 $281.28 for outpatient hospital services rendered on September 13, 2019. The insurance carrier reduced the disputed services based on workers' compensation fee schedule.

   28 TAC §134.403 (f) (1) indicates the Medicare facility specific reimbursement is 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* amount and any applicable outlier payment amount shall be multiplied by 200 percent to determine the reimbursement amount.

   This calculation is shown below.

Procedure Code	Status Indicator	APC	Payment Rate	60% labor related	2019 Wage Index Adjustment for provider 0.8410	40% non-labor related	Payment	Maximum allowable reimbursement
72141	Q3	5523	$230.56	$138.34	$112.61	$92.22	$204.83	$409.66

2. The allowable of the service in dispute is $409.66. The insurance carrier paid $408.72. No additional payment 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 not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute

Authorized Signature

Signature	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, 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.