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
Doctor's Hospital at Renaissance

Respondent Name
Brownsville ISD

MFDR Tracking Number
M4-20-1469-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
February 11, 2020

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: $207.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 3, 2019	Outpatient Hospital Services	$207.02	$207.02

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 denied the payment for the disputed services with the following claim adjustment codes:
   - T038 – Services not provided or authorized by designated (network/primary care) provider

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $207.02 for outpatient hospital services rendered on December 3, 2019. The insurance carrier denied the disputed services based on non-network provider.

   The carrier did not provide convincing evidence that the injured employee is enrolled in a network. The service in dispute will reviewed per applicable worker's compensation fee guideline.

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 as published annually in the *Federal Register* multiplied by 200% unless a separate request for implants is made.

   Review of the submitted medical bill found implants are not applicable. The Medicare facility specific amount is calculated as follows:

   - Procedure code G0463 is assigned APC 5012. The OPPS Addendum A rate is $115.85.

     This is multiplied by 60% for an unadjusted labor amount of $69.51, in turn multiplied by facility wage index 0.8433 for an adjusted labor amount of $58.62.

     The non-labor portion is 40% of the APC rate, or $46.34.

     The sum of the labor and non-labor portions is $104.96.

     The Medicare facility specific amount is $104.96. This is multiplied by 200% for a MAR of $209.92.

3. The total recommended reimbursement for the disputed services is $209.92. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $207.02. 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 $207.02.

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 $207.02, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order

Authorized Signature

		April 17, 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.