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
St Joseph Medical Center

Respondent Name
Granite State Insurance Co

MFDR Tracking Number
M4-20-1576-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 20, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted.

Amount in Dispute: $84.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider has already been reimbursed pursuant to Medical Fee Guidelines and is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 6, 2019	Outpatient Hospital Services	$84.27	$84.06

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:
   - Workers' compensation jurisdictional fee schedule adjustment
   - Your billing has been paid in accordance with the Inpatient Hospital Fee Schedule or the Outpatient fee schedule
   - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

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 $84.27 for outpatient hospital services rendered in November 2019. The insurance carrier reduced the disputed services based on workers compensation fee schedule.

   28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   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 medical bills allowable calculation is based on 28 §TAC 134.403 that allows the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment to be multiplied by 200 percent when no request for separate reimbursement of implants is made.

   Calculation of the medical bill based on the above is as follows:

   - Procedure code 26037 has status indicator J1, this code is assigned APC 5113. The OPPS Addendum A rate is $2,623.34. This is multiplied by 60% for an unadjusted labor amount of $1,574.00, in turn multiplied by facility wage index 1.0021 for an adjusted labor amount of $1,577.31.

     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 $1,049.34.

     The sum of the labor and non-labor portions is $2,626.65. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $2,626.65. This is multiplied by 200% for a MAR of $5,253.30.

   - Procedure code 26410 also has a status indicator of J1. The Medicare payment policy requires when two procedures have a J1 status indicator the highest-ranking code is paid while the other is bundled. The ranking of Code found at www.cms.gov, Addendum B is 2,820. The ranking of code 26037 is 1,946, the highest ranking. Code 26410 is bundled and not separately payable.

   - Procedure code J3010 has status indicator N, for packaged codes with no separate payment
   - Procedure code J2250 has status indicator N, for packaged codes with no separate payment
   - Procedure code J1885 has status indicator N, for packaged codes with no separate payment
   - Procedure code J1100 has status indicator N, for packaged codes with no separate payment

2. The total recommended reimbursement for the disputed services is $5,253.30. The insurance carrier paid $5,169.24. The amount due is $84.06. 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 $84.06.

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 $84.06, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 19, 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.