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
Doctor's Hospital at Renaissance

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-20-1591-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
February 24, 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."

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The hospital outpatient allowance was calculated according to the APC rate, plus a mark-up, which equaled the amount indicated in the dispute as expected ($4,687.59) minus the additional reduction of $2,028.36, which was the PPO discount, priced in accordance with your Coventry contract."

SUMMARY OF REQUEST

Dates of Service	Disputed Services	Disputed Amount	Outcome
October 3,2019	Outpatient Hospital Services	$2,378.00	$2,094.15

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
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
   - 45 – Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

Issues

1. Is the insurance carrier's position supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "…additional reduction of $2,028.36 which was a PPO discount, priced in accordance with your Coventry contract."

   Review of the information available to DWC, the effective start date of Avidel contract is January 31, 2020. As the disputed date of service is October 3, 2019, the respondent's position and the PPO discount will not be considered in this review.

2. The requestor is seeking additional reimbursement in the amount of $2,378.00 for outpatient hospital services rendered October 3, 2019.

   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.

   28 §TAC 134.403 states in pertinent part, 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 percent; when separate reimbursement of implants is not requested.

   Review of the submitted medical bill found implants were not requested separately. The reimbursement based on the above is:

   - Procedure code 26615 has status indicator J1, 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 0.8433 for an adjusted labor amount of $1,327.35.

     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 $2,376.69.

     The Medicare facility specific amount is $2,376.69 multiplied by 200% for a MAR of $4,753.38.

The total recommended reimbursement for the disputed services is $4,753.38. The insurance carrier paid $2,659.23. The amount due is $2,094.15. 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 $2,094.15.

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 $2,094.15, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 20, 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.