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
University Medical Center

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-20-1604-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 25, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is an outpatient surgery that should pay at the OPPS fee schedule plus the wage index."

Amount in Dispute: $4,246.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2019	Outpatient Hospital Services	$4,246.61	$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:
   - 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same date according to the NCCI edits or work comp state regs/fee schedule requirements
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers compensation jurisdictional fee schedule adjustment

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 $4,246.51 for outpatient hospital services rendered May 20, 2019. The insurance carrier denied/reduced the disputed services based on NCCI edits and 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.

   Review of the submitted medical bill found the following.

   - Procedure code 73590 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V or Code 64450.
   - Procedure code 20680 has status indicator Q2, for T-packaged codes; reimbursement is packaged with payment for any service with status indicator T or Code 64450.
   - Procedure code J0330 has status indicator N for packaged codes.
   - Procedure code J0690 has status indicator N for packaged codes.
   - Procedure code J1100 has status indicator N for packaged codes.
   - Procedure code J1170 has status indicator N for packaged codes.
   - Procedure code J2250 has status indicator N for packaged codes.
   - Procedure code J2405 has status indicator N for packaged codes.
   - Procedure code J2704 has status indicator N for packaged codes.
   - Procedure code J3010 has status indicator N for packaged codes.
   - Procedure code J7120 has status indicator N for packaged codes.
   - 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 or Code 64450
   - Procedure code 64445 has a National Correct Coding Initiative edit with code 20680. This insurance carrier's denial is supported.
   - Procedure code 64450 -59, has a Status indicator of T. The APC assigned is 5442 with an allowable of $598.81.

     The Medicare specific facility amount is found by multiplying the APC rate by 60% that results in the adjusted labor amount. The adjusted labor amount is $359.29. This amount is multiplied by the facility specific wage index that results in the adjusted labor amount or $359.29 x 0.8597 for an adjusted facility specific labor amount of $308.88.

     To calculate the non-labor portion the APC rate allowable is multiplied by 40%. This result is $239.52.

     These two results are added together ($308.88 + $239.52 = $548.40) to achieve the Medicare facility specific amount.

     28 TAC 134.403(f)(1)(A) states the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent or $548.40 x 200% = $1096.80.

2. The total recommended reimbursement for the disputed services is $,1096.80 The insurance carrier paid $1,096.80. 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	April 30, 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.