



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

St Joseph Medical Center

Respondent Name

Tx Public School WC Project

MFDR Tracking Number

M4-20-1657-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

March 5, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC."

Amount in Dispute: \$55.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 51040 with status indicator J1, cpt code was paid per OPPS fee guideline with 200% markup as not implants were requested."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 5, 2019, Outpatient Hospital Services, \$55.89, \$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
- 370 - This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 767 - Paid per O/P FG at 200%; implants not applicable or separate reimbursement (with cert) no requested per Rule 134.403(G)

**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 \$885.11 for outpatient hospital services rendered on August 23, 2019. The insurance carrier reduced the disputed services based on maximum allowable.

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](http://www.cms.gov), Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators.

The DWC fee guideline found in 28 §TAC 134.403 (f) states when a request for separate reimbursement of implants is not made, the Medicare facility specific amount will be multiplied by 200%. Calculation based on these provisions is found below.

2. The disputed service or Procedure code 51040 has status indicator J1.

This code is assigned APC 5373 with an OPPS Addendum A rate of \$1,739.75. This is multiplied by 60% for an unadjusted labor amount of \$1,043.85, which in turn is multiplied by facility wage index 0.9754 for an adjusted labor amount of \$1,018.17.

The non-labor portion is 40% of the APC rate, or \$695.90. The sum of the labor and non-labor portions is \$1,714.07.

The Medicare facility specific amount is \$1,714.07 which is multiplied by 200% for a MAR of \$3,428.14.

The total recommended reimbursement for the disputed services is \$3,428.14. The insurance carrier paid \$3,428.14. Additional payment is not 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 7, 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.**