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
Odessa Regional Medical Center

Respondent Name
Great American Alliance Insurance

MFDR Tracking Number
M4-20-1690-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 9, 2020

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $1,512.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based upon the carrier's EOB dated October 24, 2019, the recommended allowance was calculated according to the APC rate plus a markup. It is the carrier's position that the provider 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
September 10 – 12, 2019	Outpatient Hospital Services	$1,512.50	$1,434.51

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
   - 95 – Plan procedures not followed
   - U03 – The billed service was reviewed by UR and authorized

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 $1,512.50 for outpatient hospital services rendered from September 10 – 12, 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.

   Review of the submitted medical bill found the following:

   - Procedure code C1713 has status indicator N is packaged codes integral to the total service packaged with no separate payment.
   - Procedure code 36415, billed September 10, 2019, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 80048, billed September 10, 2019, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 85025, billed September 10, 2019, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 73620 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into Code 20680 below.
   - Procedure code 20680 has status indicator Q2 and is assigned APC 5073. The OPPS Addendum A rate is $2,378.29, multiplied by 60% for an unadjusted labor amount of $1,426.97, in turn multiplied by the facility wage index of 0.9028 for an adjusted labor amount of $1,288.27.

     The non-labor portion is 40% of the APC rate, or $951.32. The sum of the labor and non-labor portions is $2,239.59 or the Medicare facility specific amount.

     28 TAC §134.403 requires 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 no separate request for implants is made. In this dispute, no separate request for implants was made.

     The Medicare facility specific amount of $2,239.59 is multiplied by 200% for a MAR of $4,479.18.
   - Procedure code J0690 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
   - Procedure code J1100 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
   - Procedure code J1100 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
   - Procedure code J1885 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

- Procedure code J2250 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2795 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J3070 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- 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. This code is packaged into Code 20680.

2. The total recommended reimbursement for the disputed services is $4,479.18. The insurance carrier paid $3,044.67. The amount due is $1,434.51. 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 $1,434.51.

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 $1,434.51, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 31, 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.