MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UT Health Pittsburgh

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-1692-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 9, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Texas Fee Schedule, this bill has been underpaid."

Amount in Dispute: $357.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid in bill in accordance with OPPS fee schedule, including 200% markup. No additional payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2019	Outpatient Hospital Services	$357.97	$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
   - 767 – Paid per O/P FG at 200%. Implants not applicable or separate reimbursement (with cert) not requested per rule 134.403(G).
   - 370 – The hospital outpatient allowance was calculated according to the APC rate plus a markup

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 $357.97 for outpatient hospital services rendered on November 21, 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.

   28 §TAC 134.403(f) requires the Medicare facility specific amount be multiplied by 200 per cent unless the health care provider submits a separate request for implants. Review of the submitted medical claim finds implants are not applicable. The calculation of the maximum allowed reimbursement based on the Medicare payment policy and DWC fee guideline is shown below.

2. The submitted medical bill contained the following:

   - Procedure code 70450 has status indicator Q3, for packaged codes paid through a composite but as only a single code was billed, this line is separately paid.

     This line is assigned status indicator S and assigned APC 5522. The OPPS Addendum A rate is $112.51. This is multiplied by 60% for an unadjusted labor amount of $67.51, in turn multiplied by facility wage index 0.8092 for an adjusted labor amount of $54.63.

     The non-labor portion is 40% of the APC rate, or $45.00. The sum of the labor and non-labor portions is $99.63. The Medicare facility specific amount is $99.63. This is multiplied by 200% for a MAR of $199.26.

   - Procedure code 96372 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with code 99284.

   - Procedure code 99284 has status indicator V as the criteria for comprehensive APC is not met. This code is assigned APC 5024. The OPPS Addendum A rate is $360.37. This is multiplied by 60% for an unadjusted labor amount of $216.22, in turn multiplied by facility wage index 0.8092 for an adjusted labor amount of $174.97.

     The non-labor portion is 40% of the APC rate, or $144.15. The sum of the labor and non-labor portions is $319.12. The Medicare facility specific amount is $319.12. This is multiplied by 200% for a MAR of $638.24.

The total recommended reimbursement for the disputed services is $837.50. The insurance carrier paid $838.29. 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

____________________	____________________	April 7, 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.