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
UT Health East Texas

Respondent Name
Trumbull Insurance Co

MFDR Tracking Number
M4-20-1719-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 2, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill has been underpaid according to the Critical Access Hospital Rates."

Amount in Dispute: $550.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dates of service in dispute were processed in accordance with Texas Workers' Compensation Guidelines, 28 TAC §134.403."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2019	Outpatient Hospital Services	$550.48	$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
   - 802 – Charge for this procedure exceeds the OPPS schedule allowance
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

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 $550.48 for outpatient hospital services rendered December 1, 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, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators.

   The DWC fee guideline based found in 28 TAC §134.403 and states when separate payment of implants is not requested, the Medicare facility specific amount will be multiplied by 200%.

   The calculation based on the above is found below.

2. Review of the submitted medical bill finds the following:

   - Procedure code 73610 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V or in this case code 99284 which has a status indicator of V.
   - Procedure code 70450 and 72125, have status indicators of Q3, for packaged codes paid through a composite APC. These codes are combined into composite APC 8005.

     The OPPS Addendum A rate is264.95. This is multiplied bye 60% for an unadjusted labor amount of $158.97, in turn multiplied by facility wage index of 0.8092 for an adjusted labor amount of $128.64,

     The non-labor portion is 40% of the APC rate, or $105.98. The sum of the labor and non-labor portions is $234.62.

     The Medicare facility specific amount is $234.62 multiplied by 200% equals a MAR of $469.24.
   - Procedure code 99284 has status indicator of V as the criteria for J2 Comprehensive Observation Services 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.

     (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 $144.15. The sum of the labor and non-labor portions is $319.12.

     The Medicare facility specific amount is $319.12 multiplied by 200% for a MAR of $638.24.

The total recommended reimbursement for the disputed services is $1,107.48. The insurance carrier paid $1,108.52. 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 2, 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.