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
Surgical Specialty Hospital

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-20-1747-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
March 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier is required to reimburse Provider $21,067.77 pursuant to the Outpatient Fee Guideline."

Amount in Dispute: $649.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider was properly reimbursed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 31, 2019	Outpatient Hospital Services	$649.41	$649.41

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:
   - 97 – Payment adjusted because 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

- P18 – Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service
- 96 – Non-covered charge(s)

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 $649.41 for outpatient hospital services rendered on July 31, 2019. The insurance carrier reduced the disputed services based on workers' compensation fee schedule and bundling of charges.

   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 is found in 28 TAC 134.403 (f)(1) and states 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 separate reimbursement of implants is not made.

   The calculation of the Medicare facility specific amount and DWC fee guideline is shown below.

2. Review of the submitted medical bill found the following services were billed:
   - Procedure code C1713 has status indicator N for packaged service, no separate payment recommended.
   - Procedure code C1769 has status indicator N for packaged service, no separate payment is recommended.
   - Procedure code 27709 has status indicator J1 and is paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5115. The OPPS Addendum A rate is $10,713.88, multiplied by 60% for an unadjusted labor amount of $6,428.33, in turn multiplied by the facility wage index of 0.9754 for an adjusted labor amount of $6,270.19.

     The non-labor portion is 40% of the APC rate, or $4,285.55. The sum of the labor and non-labor portions is $10,555.74. This total is the Medicare facility specific amount

     The Medicare facility specific amount of $10,555.74 is multiplied by 200% for a MAR of $21,111.48.
   - Procedure code 27418 is a lower ranked comprehensive code or J1 and is packaged into code 27709.
   - Procedure code 29876 is a lower ranked comprehensive code or J1 and is packaged into code 27709.
   - Procedure code 64445 has a status indicator of T and is bundled into code 27709.
   - Procedure code 76942 has status indicator N for packaged service, no separate payment recommended.
   - Procedure code J3370 has status indicator N for packaged service, no separate payment is recommended.

- Procedure code J0690 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J0131 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J2795 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J2405 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J3490 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J2704 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J3010 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J1644 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J0171 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J7030 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J1100 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J1885 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J2250 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J2001 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J1580 has status indicator N for packaged service, no separate payment recommended.
- Procedure code J8499 has status indicator E1, for excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.

The total recommended reimbursement for the disputed services is $21,111.48. The insurance carrier paid $20,418.36. The requestor is seeking additional reimbursement of $649.41. 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 $649.41.

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 $649.41, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order

Authorized Signature

		April 8, 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.