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
Texas Health Plano

Respondent Name
WC Solutions

MFDR Tracking Number
M4-20-1773-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 19, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $6,083.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The status indicator for procedure 99285 is J2; therefore, the other charges in dispute do not warrant separate reimbursement."

Response Submitted by: Review Med

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 7 - 8, 2019	Outpatient Hospital Services	$6,083.03	$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:
   - 193 – Original payment decision is being maintained
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are now recommending further payment to be made for the above noted procedure code

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 $6,083.03 for outpatient hospital services rendered on August 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.

   The DWC fee calculation is found in 28 TAC 134.403 (f) and states the Medicare facility specific amount is to be multiplied by 200 percent when separate reimbursement for implants is not made. Review of the submitted medical bill found that implants are not applicable. Calculation of the Medicare facility specific amount and DWC fee guideline is found below.

   - Procedure code 71260 has status indicator Q3 and is packaged into the comprehensive code 99285 below.
   - Procedure code 96361 has a status indicator S and is packaged into the comprehensive code 99285 below.
   - Procedure code 96374 has a status indicator S and is packaged into the comprehensive code 99285 below.
   - Procedure code 96375 has a status indicator S and is packaged into the comprehensive code 99285 below.
   - Procedure code 99285 has status indicator J2 as the criteria for comprehensive packaging of 8 or more hours observation billed was met. This code is assigned APC 8011.

     The OPPS Addendum A rate is $2,386.80, multiplied by 60% for an unadjusted labor amount of $1,432.08, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $1,394.27.

     The non-labor portion is 40% of the APC rate, or $954.72. The sum of the labor and non-labor portions is $2,348.99.

     The Medicare facility specific amount of $2,348.99 is multiplied by 200% for a MAR of $4,697.98.

2. The total recommended reimbursement for the disputed services is $4,697.98. The insurance carrier paid $4,697.98. 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 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.