MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

St Joseph Medical Center

Respondent Name

Worth Casualty Co

MFDR Tracking Number

M4-20-1792-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

March 24, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "None submitted."

Amount in Dispute: $4,208.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After reviewing the bill, we have determined that the correct allowance has been paid per the fee guidelines (Medicare OPPS plus applicable mark-up) and no additional allowance is being recommended."

Response Submitted by: Salus

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 23, 2019	Outpatient Hospital Services	$4,208.03	$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:
   - 97- Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 802 – Charge for this procedure exceeds the OPPS schedule allowance
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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 $4,208.03 for outpatient hospital services rendered on August 23, 2019. The insurance carrier reduced the disputed services based on workers compensation fee schedule and OPPS 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 in the Medicare Hospital Outpatient Prospective Payment System.

   28 §TAC 134.403 (f) requires that the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent. The calculation of the Medicare facility specific amount and the DWC fee guideline is shown below:

   - Procedure code 84703 has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
   - Procedure code 87015 has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
   - Procedure code 87102 has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
   - Procedure code 87116 has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
   - Procedure code 87206 has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
   - Procedure code 20680 has status indicator Q2 reimbursement is packaged with payment for any service with status indicator T.
   - Procedure code 11043 has a status indicator of T. The APC is 5053 with a rate of $482.89.
     The facility specific amount calculation is done by multiplying the Medicare rate by 60% to receive a labor amount of $289.73.
     This amount is multiplied by the facility wage index of 0.9754 to achieve the adjusted labor rate of $282.60.
     The non-labor portion or 40% of the APC rate is $193.16.
     These two amounts are combined for an APC payment of $475.76.
     This amount is multiplied by 200% for a MAR (maximum allowable reimbursement) of $951.52
   - Procedure code J3010 has status indicator N reimbursement is included with payment for the primary services.
   - Procedure code J2250 has status indicator N reimbursement is included with payment for the primary services.
   - Procedure code J1885 has status indicator N reimbursement is included with payment for the primary services.
   - Procedure code J1100 has status indicator N reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is $951.52. The insurance carrier paid $951.52. Additional payment is not recommended.
3.

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 17, 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.