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
St Joseph Medical Center

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-1793-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 24, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted.

Amount in Dispute: $84.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual issued payment in accordance with OPPS fee schedule, including 200% markup. This is consistent with Rule 134.403 (f)."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 13, 2019	Outpatient Hospital Services	$84.27	$84.06

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
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup

- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS
- 767 – Paid per O/P FG at 200%; implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(G)
- 193 – Original payment decision is being maintained

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 $84.27 for outpatient hospital services rendered December 13, 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)(1) 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 if implants are not applicable. Review of the submitted medical bill finds implants do not apply.

   The calculation of the Medicare facility specific amount is as follows:

   - Procedure code 87205 has status indicator Q4 reimbursement is included with payment for the primary services.
   - Procedure code 87075 has status indicator Q4 reimbursement is included with payment for the primary services.
   - Procedure code 87070 has status indicator Q4 reimbursement is included with payment for the primary services.
   - Procedure code 26037 has status indicator J1 and APC 5113. The OPPS Addendum A rate is $2,623.34.

     This is multiplied by 60% for an unadjusted labor amount of $1,574.00, in turn multiplied by facility wage index 1.0021 for an adjusted labor amount of $1,577.31.

     (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 $1,049.34.

     The sum of the labor and non-labor portions is $2,626.65.

     The Medicare facility specific amount is $2,626.65. This is multiplied by 200% for a MAR of $5,253.30.
   - 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 $5,253.30. The insurance carrier paid $5,169.24. The amount due is $84.06. 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 $84.06.

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 $84.06, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

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.