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
Doctor's Hospital at Renaissance

Respondent Name
Employers Insurance Co of Wausau

MFDR Tracking Number
M4-20-1894-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
April 10, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We rendered services on good faith based on the information that was exchanged and therefore are also requesting that our claim be reprocessed for payment."

Amount in Dispute: $306.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute was reviewed and the bill for DOS 03/13/2019 has been adjusted for processing as provider has submitted proof of being billed within 95 days for DOS. However, the compensable injury for this claim does not include the eyes as PLN11 filed states, Carrier denied that eye treatment is related to the compensable injury of [redacted]."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 13, 2019	Outpatient Hospital Services	$306.90	$207.02

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:
   - 4271 – Per TX Labor Code Sec.413.016, Providers must submit bills to payors within 95 days of the date of service

- 249 – This billing is for a service unrelated to the work illness or injury

The respondent indicates the original denial for timely filing is not being maintained but at the time of this review they denied indicating the billed service is not related to the compensable injury. 28 TAC 133.307 (d)(2)(F) allows a response to address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party.

The date of the request for MFDR was received was April 10, 2020. The date of the explanation of benefits that denied for relatedness was April 17, 2020. Based on the above, this denial will not be considered in this review.

The disputed services will be reviewed based on the applicable fee guideline.

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 reimbursement in the amount of $306.90 for outpatient hospital services rendered on March 13, 2019. 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) states when separate reimbursement for implants is not requested or does not apply 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.* The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent.

   The fee calculations based on the Medicare Payment Status Indicator and the Medicare facility specific amount is as follows:

   - Procedure code G0463 has status indicator J2 when comprehensive observation criteria is met. As no observations was billed, this code has a status indicator of V and is assigned APC 5012.

     The OPPS Addendum A rate is $115.85, multiplied by 60% for an unadjusted labor amount of $69.51, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $57.17.

     The non-labor portion is 40% of the APC rate, or $46.34. The sum of the labor and non-labor portions is $103.51.

     The Medicare facility specific amount of $103.51 is multiplied by 200% for a MAR of $207.02.

   - Procedure code 92134 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged.

2. The total recommended reimbursement for the disputed services is $207.02. The insurance carrier paid $0.00. The amount due is $207.02. 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 $207.02.

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 $207.02, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 24, 2020 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.