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
ESSENT PRMC

Respondent Name
Nationwide Agribusiness Insurance Co

MFDR Tracking Number
M4-20-2100-01

Carrier's Austin Representative
Box Number 6

MFDR Date Received
April 30, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted.

Amount in Dispute: $2,204.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was re-evaluated for payment and it was determined additional payment of $190.93 is due bringing the total allowance to $1,921.22

Response Submitted by: Genex

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 23, 2019	Outpatient Hospital Services	$2,204.92	$190.97

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:
    - 131 – Claim specific negotiated discount
    - 97 – 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

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

Issues

1. Is the insurance carrier's reduction in payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is additional payment due?

Findings

1. The requestor is seeking additional reimbursement in the amount $2,204.92 for outpatient hospital services rendered on December 23, 2019. The insurance carrier reduced the disputed services based on claim specific negotiated discount. Review of the explanation of benefits indicated First Health Network and a PPO reduction.

   Although First Health is listed as a certified network on the Division's webpage, the carrier did not provide convincing evidence that the injured employee is enrolled in this network, nor did the carrier provide documentation to support that the requestor is contracted with First Health. The services in dispute will be reviewed per applicable fee guideline.

2. 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 and Ambulatory Payment Category (APC).

   28 TAC 134.403 (f) states in pertinent part 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 Inpatient Prospective Payment System (IPPS) 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 143 percent when a separate request for implant reimbursement is not made and 108 percent when separate reimbursement for implants is made.

   The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non labor portion determines the Medicare specific amount.

   Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - Procedure code 96372 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. No separate payment is recommended.
   - Procedure code 96374 has status indicator S and assigned APC 5693. The OPPS Addendum A rate is $187.18. This is multiplied by 60% for an unadjusted labor amount of $112.31, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $108.44. (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 $74.87. The sum of the labor and non-labor portions is $183.31.

     The Medicare facility specific amount is $183.31. This is multiplied by 200% for a MAR of $366.62.
   - Procedure code 96375 has status indicator S and is assigned APC 5691. The OPPS Addendum A rate is $37.88. This is multiplied by 60% for an unadjusted labor amount of $22.73, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $21.95. (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 $15.15. The sum of the labor and non-labor portions is $37.10.

The Medicare facility specific amount is $37.10. This is multiplied by 200% for a MAR of $74.20.

- Procedure code 99285 is assigned APC 5025 with a status indicator of V. The OPPS Addendum A rate is $525.30. This is multiplied by 60% for an unadjusted labor amount of $315.18, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $304.31.

  The non-labor portion is 40% of the APC rate, or $210.12. The sum of the labor and non-labor portions is $514.43.

  The Medicare facility specific amount is $514.43. This is multiplied by 200% for a MAR of $1,028.86.

- Procedure code 72148 has status indicator Q3, for a composite APC as only one service was billed, this line is separately paid. This code is assigned APC 5523. The OPPS Addendum A rate is $230.56. This is multiplied by 60% for an unadjusted labor amount of $138.34, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $133.57.

  The non-labor portion is 40% of the APC rate, or $92.22. The sum of the labor and non-labor portions is $225.79.

  The Medicare facility specific amount is $225.79. This is multiplied by 200% for a MAR of $451.58.

- Procedure code J1170 has status indicator N is included with payment for the primary services.
- Procedure code J1885 has status indicator N is included with payment for the primary services.
- Procedure code J2360 has status indicator N is included with payment for the primary services.
- Procedure code J2405 has status indicator N is included with payment for the primary services.

3. The total recommended reimbursement for the disputed services is $1,921.26. The insurance carrier paid $1,730.29. The amount due is $190.97.

   The respondent stated in their position statement that an additional payment was to be made however, at the time of this review insufficient evidence was found to support this additional payment was made. A balance of $190.97 is due to the requestor.

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 $190.97.

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 $190.97, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 15, 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.