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
Southwest General Hospital

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-20-2285-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 15, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT scans should be paid separately from the J2."

Amount in Dispute: $836.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The CPT code 99248 included on the bill has a status indicator of J2. When this indicator is present, all other services are packed (bundled)..."

Response Submitted by: TASB Risk Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2020	Outpatient Hospital Services	$836.70	$772.14

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 – Payment is included in the allowance for another service/procedure
   - 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 $836.70 for outpatient hospital services rendered on January 10, 2020. The insurance carrier reduced the disputed services based on the workers' compensation fee schedule.

   The fee schedule guidelines for the disputed services is found in 28 TAC §134.403 (d) and 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.

   Review of the submitted medical bill found the submitted HCPCS code have the following APC classification.

   - Procedure code 36415 has status indicator Q4 reimbursement is packaged.
   - Procedure code 80053 has status indicator Q4 reimbursement is packaged.
   - Procedure code 85025 has status indicator Q4 reimbursement is packaged.
   - Procedure code 81003 has status indicator Q4 reimbursement is packaged.
   - Procedure code 70450 and 72125 have status indicator Q3. Both are in composite APC 8005 which has a status indicator of S.

     The OPPS Addendum A rate is $242.04. This is multiplied by 60% for an adjusted labor amount of $145.22, in turn multiplied by facility wage index 0.842 for an adjusted labor amount of $122.28.

     The non-labor portion is 40% of the APC rate or $96.82.

     The sum of the labor and non-labor portions is $219.10.

     The Medicare facility specific amount is $219.10. Per provisions of 28 TAC 134.403 (f) this amount is multiplied by 200% for a MAR of $438.20
   - Procedure code 96374 has a status indicator of S. The APC is 5693 with an allowable $183.74. This is multiplied by 60% for an adjusted labor amount of $110.24, in turn multiplied by facility wage index of 0.842 for an adjusted labor amount of $92.82.

     The non-labor portion is 40% of the APC rate or $73.50.

     The sum of the labor and non-labor portions is $166.32.

     The Medicare facility specific amount is $166.32. Per provisions of 28 TAC 134.403 (f) this amount is multiplied by 200% for a MAR of $332.64
   - Procedure code 96375 has a status indicator of S. The APC is 5691 with an allowable $38.11. This is multiplied by 60% for an adjusted labor amount of $22.87, in turn multiplied by facility wage index of 0.842 for an adjusted labor amount of $19.26.

     The non-labor portion is 40% of the APC rate or $15.24.

     The sum of the labor and non-labor portions is $34.50.

     The Medicare facility specific amount is $34.50. Per provisions of 28 TAC 134.403 (f) this amount is multiplied by 200% for a MAR of $68.00

- Procedure code 99284 is classified as a Level 4, Type A ED Visit with a status indicator of V as the criteria for J2 comprehensive code is not met. This code is assigned APC 5024. The OPPS Addendum A rate is $351.79. This is multiplied by 60% for an unadjusted labor amount of $211.07, in turn multiplied by facility wage index 0.842 for an adjusted labor amount of $177.72.

  The non-labor portion is 40% of the APC rate, or $140.72.

  The sum of the labor and non-labor portions is $318.44.

  The Medicare facility specific amount is $318.44. This is multiplied by 200% for a MAR of $636.88.
- Procedure code J0780 has status indicator N reimbursement is packaged.
- Procedure code J1200 has status indicator N reimbursement is packaged.
- Procedure code J1885 has status indicator N reimbursement is packaged.

2. The total recommended reimbursement for the disputed services is $1,475.72. The insurance carrier paid $703.58. The amount due is $772.14. 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 not established payment is due. As a result, the amount ordered is $772.14.

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 $772.14, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 5, 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.