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
Houston Methodist San Jacinto

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-20-2362-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 22, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is an outpatient bill that should pay per OPPS fee schedule per TDI Rule 134.403."

Amount in Dispute: $448.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fund has made total payments of $445.98 based on the maximum allowable reimbursement as per the OPPS fee guideline which indicates reimbursement should be 200% of Medicare's allowable unless separate reimbursement for implants is requested as per Rule 134.403(f)."

Response Submitted by: TASK Risk Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 20, 2019	Outpatient Hospital Services	$448.00	$448.00

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:
    - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier's response supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $448.00 for outpatient hospital services rendered on December 20, 2019. The insurance carrier states in their position, "The CPT code 99283 included on the bill has a status indicator of J2. When this indicator is present, all other services are packaged (bundled)…"

   Review of Addendum B of the OPPS annual files at www.cms.gov found Code 99283 does have a status indicator of J2. However, the definition of J2 is "comprehensive payment criteria." Specifically, the criteria for J2 requires a combination of emergency room services and eight or more hours of observation. Based on the submitted medical bill, the criteria is not met.

   The APC for Code 99283 is 5023 titled "Level 3 Type A ED Visit" with a status indicator of "V". The insurance company's position is not supported. The codes in dispute are reviewed below.

2. The DWC060 found codes 70450 and 72125 are in dispute. These codes have a status indicator of Q3 for a Composite APC of 8005 with a status indicator of "S".

   The payment rate is $264.95. To calculate the adjusted labor amount this rate is multiplied by 60% or $158.97 which in turn is multiplied by the facility specific wage index of 1.0021 for a total of $159.30.

   The non-labor portion is multiplied by 40% or $105.98. For a total of $265.28.

   28 TAC 134.403 (f)(1)(A) requires this amount to be multiplied by 200% or $530.56.

3. The requestor is seeking $448.00. 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 $448.00.

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 $448.00, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

____________________	____________________	June 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.