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
Medical Center of Southeast Texas

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-20-2426-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 5, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "When Q3 and J2 are billed together, they both should receive payment per TX fee schedule."

Amount in Dispute: $600.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fund has made total payments of 1,009.02 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: TASB Risk Mgmt Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 27, 2020	Outpatient Hospital Services	$600.15	$600.15

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:
    - 97 – Payment is included in the allowance for another service/procedure
    - 193 – Original payment decision is being maintained
    - P12 – Workers' compensation jurisdictional fee schedule adjustment

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 $600.15 for outpatient hospital services rendered on January 27, 2020. The insurance carrier reduced the disputed services based on bundling and 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 and Ambulatory Payment Category (APC).

   Review of the submitted medical bill and the applicable fee guideline is shown below.

   - Procedure code 36415 has status indicator Q4 reimbursement is included with payment for the primary services.
   - Procedure code 80053 has status indicator Q4 reimbursement is included with payment for the primary services.
   - Procedure code 83690 has status indicator Q4 reimbursement is included with payment for the primary services.
   - Procedure code 84703 has status indicator Q4 reimbursement is included with payment for the primary services.
   - Procedure code 85025 has status indicator Q4 reimbursement is included with payment for the primary services.
   - Procedure code 81003 has status indicator Q4 reimbursement is included with payment for the primary services.
   - Procedure code 74177 has status indicator Q3, for conditionally packaged codes paid as a composite if OPPS criteria are met. As packaging criteria were not met, this line is separate.

     This code is assigned APC 5572 and a Status Indicator of S. The OPPS Addendum A rate is $381.85. This is multiplied by 60% for an unadjusted labor amount of $229.11, in turn multiplied by facility wage index 0.8512 for an adjusted labor amount of $195.02.

     The non-labor portion is 40% of the APC rate, or $152.74. The sum of the labor and non-labor portions is $347.76.

     The Medicare facility specific amount is $347.76. Per provisions of 28 TAC §134.403 (f) this is multiplied by 200% for a MAR of $695.52.

   - Procedure code 99285 has status indicator J2 if the criteria for comprehensive specific payment is met. In this instance, eight hours of more of observation must be billed in addition to the emergency room code to qualify for J2 payment. As the criteria is not met, this code is assigned APC 5025, Level 5 Type A ED Visits with a Status Indicator of V.

     The OPPS Addendum A rate is $504.51. This is multiplied by 60% for an unadjusted labor amount of $302.71, in turn multiplied by facility wage index 0.8512 for an adjusted labor amount of $257.67.

     The non-labor portion is 40% of the APC rate, or $201.80. The sum of the labor and non-labor portions is $459.47.

     The Medicare facility specific amount is $459.47. Per provisions of 28 TAC §134.503 (f) this is multiplied by 200% for a MAR of $918.94.

2. The total recommended reimbursement for the disputed services is $1,614.46. The insurance carrier paid $1,009.02. The requestor is seeking additional reimbursement of $600.15. 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 $600.15.

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 $600.15, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 17, 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.