



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

St Joseph Medical Center

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-20-2656-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

July 6, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: \$2,633.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Ace American Insurance Co is Downs Stanford who was notified of this medical fee dispute on July 14, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2019	Outpatient Hospital Services	\$2,633.94	\$15.48

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 services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 275 – The charge was disallowed; as the submitted report does not substantiate the services being billed

- B12 – Services not documented in patient's medical record

Issues

1. Is the insurance carrier's denial of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered on December 16, 2019. The insurance carrier denied Code 13160 as not being documented or supported in the medical record.

28 TAC §134.403 (d) states in pertinent part for coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

28 TAC 134.403 (b) (3) states in pertinent part Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies.

The description of Code 13160 is, "Secondary closure of surgical wound or dehiscence, extensive or complicated." Review of the submitted medical record found insufficient evidence to support the procedure was extensive or complicated. The insurance carrier's denial is supported.

2. 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 11760 has status indicator T. The OPPS Addendum A rate is \$482.89. This is multiplied by 60% for an unadjusted labor amount of \$289.73, in turn multiplied by facility wage index 1.0021 for an adjusted labor amount of \$290.34. (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 \$193.16.
The sum of the labor and non-labor portions is \$483.50.
The Medicare facility specific amount is \$483.50 is multiplied by 200% for a MAR of \$967.00.
- Procedure code J2250 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

The total recommended reimbursement for the disputed services is \$967.00. The insurance carrier paid \$951.52. The amount due is \$15.48. 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 \$15.48.

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 \$15.48, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 18, 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.